MEDICARE WASTE, FRAUD, AND ABUSE: A REGIONAL PERSPECTIVE

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OVERSIGHT AND INVESTIGATIONS

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HOUSE OF REPRESENTATIVES

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MEDICARE WASTE, FRAUD, AND ABUSE: A REGIONAL PERSPECTIVE

MONDAY, MARCH 2, 1998

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Colleyville, TX.

The subcommittee met, pursuant to notice, at 3:30 p.m., in The Assembly Hall, Colleyville Community Center, 5300 Bluebonnet Drive, Colleyville, Texas, Hon. Joe Barton (chairman) presiding.

Members present: Representatives Barton, Ganske, and Coburn.

Staff Present: Matthew D. Saylor, majority counsel.

Mr. BARTON. The Subcommittee on Oversight and Investigations for the Commerce Committee for the U.S. House of Representatives will come to order. I am Congressman Joe Barton, I am the chairman. With me, I have Congressman Greg Ganske of Iowa and Congressman Tom Coburn of Oklahoma.

Congressman Ron Klink, the ranking minority member from Pittsburgh, was scheduled to attend, but could not attend because of a death in the family. I have been asked to enter into the record his statement, dated February 27, 1998, to the Honorable Joe Barton, Chairman, Subcommittee on Oversight and Investigations.

"Dear Mr. Chairman, regrettably due to the recent passing of my father-in-law, I will not be able to attend the Oversight and Investigations Field Hearing in Texas on March 2. I want to commend your interest in waste, fraud, and abuse, and encourage that as you have stated, 'It will only be the beginning of a series of health care hearings you intend to hold on that issue.' In particular, I appreciate your willingness to look to other venues such as Pittsburgh for additional field hearings.

"Lastly, I would appreciate it if you would have this letter entered into the record so that the record is clear as to why I am not able to attend. I look forward to working with you on these and other important issues. Sincerely, Congressman Ron Klink, Member of Congress, State of Pennsylvania." So that letter is entered into the record. I want to thank the city of Colleyville for hosting us in this beautiful new community center. It's been opened approximately 1 month, I am told.

Today, we are going to continue a series of hearings related to Medicare waste, fraud, and abuse. We have been reviewing this issue in Washington and will continue to do so, but I wanted to come to Texas today to gain a regional perspective on the problem and to hear from those who fight it daily as well those who see firsthand what is happening in their particular industry.

As chairman of the Oversight and Investigations Subcommittee, I am committed to assuring that Medicare tax dollars, your money, will be used to pay for health care costs of our elderly and not used to fund Medicare schemes of the month. The theft or misuse of billions in Medicare dollars every year deprives elderly beneficiaries of the health care that they so dearly depend on.

Medicare provides Federal health insurance for approximately 38 million Americans. By the year 2000, it is expected that Medicare will process over 1 billion claims annually and pay out more than $242 billion in benefits. As the government's largest health program, Medicare accounts for 13 percent of all Federal spending. And it unfortunately continues to be an attractive target for unscrupulous providers.

In a report released last July, the Inspector General of the Department of Health and Human Services, estimated that in fiscal year 1996, improper payments totaled over $23 billion. I understand that the Inspector General did not quantify what amount was attributable to fraud, simply instead stating that improper payments ranged from inadvertent mistakes to outright fraud and abuse.

Let me tell you, taxpayers, whether we are dealing with outright fraud or mere mistakes, neither helps to alleviate the concern and the pain of the taxpayers, who lose no matter how you look at it. Texas, unfortunately, has not been immune to the problems associated with Medicare waste, fraud, and abuse. We have over 2.1 billion beneficiaries in our State. Medicare last year paid over $12.7 billion.

The potential for fraud and abuse in Texas is very real indeed. While Texas and the rest of the Nation have been hit hard by Medicare fraud and abuse, I do want to commend the efforts of the Department of Health and Human Services in its Operation Restore Trust, a 2-year demonstration project, in which Texas was 1 of the 5 States selected to be involved.

Operation Restore Trust was kicked off in May 1995 to address the rapidly increasing costs in Medicare. It targeted home health agencies, nursing homes, and durable medical equipment suppliers in Texas, California, Illinois, Florida, and New York. Those States account for over 40 percent of the total Medicare expenditures nationwide.

Under Operation Restore Trust, Federal and State representatives, including HHS, the Department of Justice, the FBI, the U.S. Attorney's Office, State Attorney's General, and State Medicaid Fraud Control units, coordinated enforcement efforts to fight Medicare fraud and abuse. Because of this effort, more than a $188 million has been identified as being owed to the Federal Government. This constitutes return of more than $23 for every dollar spent. I applaud these efforts and everyone involved in this fight and I am very glad to hear that the project has been expanded into 12 additional States.

That said, I remain concerned about the Clinton Administration's efforts to fight waste, fraud, and abuse on all fronts. I am still concerned about HCFA'S failure to implement commercially available computer technology to detect improper claims and stop payments

before they leave the Federal Treasury as opposed to the pay and chase method that Operation Restore Trust has used.

This committee has been actively reviewing the potential benefits of implementing commercial off-the-shelf software, commonly called COTS. The General Accounting Office has reported that it could save hundreds of millions of dollars annually in improper Medicare payments.

After resisting the GAO recommendation for years, HCFA, has undertaken a pilot project in the last couple of years to test this technology. Most recently, the committee's vigorous oversight efforts, which included a hearing on this subject this past September in Washington, insured that HCFA will conduct and continue to conduct this pilot program in a fair manner.

HCFA now estimates that it could save as much as $465 million annually if it were to implement COTS on a nationwide scale. The new Administrator, who is with us today, and I have personally discussed this issue, and I believe she is committed to implementing this kind of software nationwide without undue delay if it's proven that it will save taxpayer dollars.

As chairman of the oversight subcommittee, I am very proud of role that we have and our members have played in enacting tough new Medicare requirements as a part of the Balanced Budget Act of 1997. I, myself, promoted provisions in the BBA which set up a pilot program for competitive bidding for Medicare durable medical equipment and supplies. This means that there should be some new incentives to restrain the explosive costs of Medicare. These changes should go a long way in fighting the waste and fraud that is currently plaguing the Medicare system.

I am aware, though, that there are concerns about some of these new provisions in our Balanced Budget Amendment and I am sure that those concerns are going to be brought out in the testimony of the witnesses that we have today. Both the home health care industry and Medicare beneficiaries are concerned, for example, with the surety bond requirement and also the provision on drawing of blood and the new prospective pay reimbursement system. It's my hope that information gathered here today will provide insight as to how the fraud and abuse provisions will interact, to actually save taxpayer dollars without imposing on quality health care.

I am very pleased to have with us today, Ms. Nancy-Ann Min DeParle, the newly confirmed Administrator at the Health Care Financial Administration. It means a great deal to me and to the subcommittee that she took time to fly down from Washington to be with us at our field hearing. She has asked in a hearing that we held in Washington not too many months ago to be held accountable. This committee will do that, but I must say that she is going above and beyond the duty to be accessible as we begin to work to be accountable. I know that she is equally as eager to root out the waste, fraud, and abuse that is currently in the system as any member of the subcommittee that is on the panel today.

I am also very pleased to have with us Mr. Paul Coggins, the United States Attorney for the Northern District of Texas, and Mr. Robert Richardson, the Assistant Inspector General for Criminal Investigations of the Department of Health and Human Services. Both of these gentleman have been fighting Medicare waste, fraud,

and abuse, and they both know the problems better than most in their area.

We will also be hearing from representatives of various industries to learn their perspective. For example, we will hear from Mr. Donald Chrysler, who owns a pharmacy and durable medical equipment business in Amarillo, Texas. We will also hear from Ms. Claudia Foster, who owns a home health agency in Waxahachie. And Dr. Bohn Allen, who will give us a perspective from the Texas Medical Association on doctors' views. I will welcome all of our witnesses at the appropriate time.

Would the gentleman from Iowa, Mr. Ganske, wish to make an opening statement?

Mr. GANSKE. Mr. Chairman, I think the people of this community should be very proud to have such a lovely community center that we are in today. I think that government has a commitment that each person has a right to receive certain services to promote health, to correct the effects of illness or trauma, to carry on as many activities of their daily living as possible when confronted with chronic disease, to receive pain alleviation, and to receive comfort when they're dying.

I think our government also has a responsibility to a vision shaped by a realistic understanding of the resources available to a community and of the amount of those resources that society is willing to commit to the delivery of health care. That in a nutshell is the big dilemma that we are all facing when we are talking about how to deliver Medicare Health Care Services to the elderly.

Well, there is no question that we can do it better than we have done in the past. We are dealing with a $200 billion a year program. The Congress and the administration have a responsibility to make sure that those hard earned taxpayer dollars are spent on health care that's necessary for its citizens. So today we are going hear, I think, some very interesting testimony on how to tighten up the program to try to control the abuse and to make sure that our citizens get the full value of the tax dollars that all the citizenry is providing for them. And I really look forward to the testimony from our HCFA Administrator, Nancy-Ann Min DeParle.

And also I have looked over, Mr. Chairman, the testimony of our second panel, and I think it's excellent in terms of some of the problems that we are going to have to address to make sure that government carries out this program better than it has in the past.

Mr. BARTON. Thank you, Congressman Ganske. I will point out that Congressman Ganske is a surgeon and has practiced medicine until he was elected to Congress 3 years ago. We also have with us Congressman Tom Coburn of Oklahoma, who is a practicing physician in Tulsa, Oklahoma, and was seeing patients this morning before he flew down to the field hearing. Congressman Coburn.

Mr. COBURN. Thank you, Mr. Chairman. I just have a brief comment. The problems that we face in delivering health care through Medicare and Medicaid are never going to be solved until we change the incentives in the system. Where we got in trouble in home health care wasn't because people didn't want to do the right thing, but as they did the right thing oftentimes there were incentives to do a little more than what was necessary. And until we recognize that our health care in this country has to have incen-

tives to do enough and not waste the resources of our children in the future, only then will we be able to solve the problems.

The Administrator of HCFA has an impossible job. The program is designed as it is today, it cannot be managed. It's impossible. So regardless of the quality of the people that are at HCFA, regardless of the situation, and until we change the program design, and change the incentives in the program in terms of financial, in terms of protecting what you do, when you do it, and how you do it, we will not solve these problems.

I think it is great we are having this hearing. It is interesting to hear the perspective from those away from Washington, and I am hopeful that we can learn. I think incentive in health care is the key to us solving our problems and rooting out fraud. There won't be fraud if we have the incentive to reimburse and properly care for those people that are depending on us. And I thank you for holding the hearing.

Mr. BARTON. Thank you, Congressman Coburn. Well, our first witness is already seated. It is my distinct pleasure to welcome to the subcommittee hearing, the Honorable Nancy-Ann Min DeParle, who is the Administrator of the Health Care Financing Administration. She has been confirmed by the U.S. Senate, prior to that she worked in the Office of Management and Budget as one of the Deputy OMB Directors.

Ms. DeParle, I think you know that it is the practice of this Subcommittee to take all testimony under oath. Do you have a problem testifying under oath?

Ms. DEPARLE. No, sir. I don't.

Mr. BARTON. I think you also know that the rules of the subcommittee and the Constitution of the United States, you have the right to be advised by counsel and any other technical representatives during your testimony. Do you think that you will need to be advised by counsel or need the advice of any of your technical staff?

Ms. DEPARLE. No, sir. I don't.

Mr. BARTON. Would you please rise then and raise your right hand and make sure the microphone is on. Please stand and raise your right hand.

Do you swear that the testimony you are about to give is the truth, the entire truth and nothing but the truth, so help you God?

Ms. DEPARLE. Yes.

Mr. BARTON. Your entire witness statement is included in the record. You are asked to summarize it. We will let you take such time as you may consume.

TESTIMONY OF HON. NANCY-ANN MIN DePARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. DEPARLE. All right. I will try to be brief. I wouldn't want to wear out my welcome on my first trip to Colleyville, I have enjoyed being here so far.

Mr. BARTON. And you really need to hold the microphone up to your mouth so that the people in the audience can hear you.

Ms. DEPARLE. All right. If it gets to where you can't hear me, would someone sitting behind me punch me or something.

Chairman Barton, Congressman Ganske, and Congressman Coburn, I want to thank you for convening this hearing today to

talk about one of my highest priorities: Fighting waste, fraud, and abuse in Medicare. It is a great pleasure to be here in Texas, a State that's been a pioneer in the fight against health care fraud.

I can't think of any more important place or better place to be than here today with three members of this committee who have committed themselves both to working to strengthen the Medicare program and to making sure that we are managing the program well. Every time I meet with them, you ask me about how it is working for beneficiaries and providers, and I think the three of you have really done a great job in helping us to try to run a tight ship.

Mr. Chairman, Medicare and Medicaid have literally changed what it means to be old, disabled or poor and sick in America and they are great programs. I will concentrate my remarks today mostly on Texas. And in Texas, Medicare, as you said, is serving over 2 million residents with more than 39 beneficiaries nationwide. In Texas, we are spending around $12 billion every year providing the State's elderly and disabled with over 3 million days of hospital care; 2 million days of skilled nursing home care; some 25 million physicians visits; and providing home health services to about 260,000 beneficiaries.

To be able to continue to provide these services to Texans and to continue to maintain the trust of the taxpayers and beneficiaries who are paying the bills, Medicare must have a strong anti-fraud program. We already are achieving record success in increasing fraud and abuse investigations, indictments, convictions, fines, penalties, and restitutions.

Medicare efforts alone save $7.5 billion, mostly by making sure inappropriate payments were not made in the first place. Last year law enforcement efforts returned nearly a billion dollars to the Medicare trust fund. Thanks to our partnership with other Federal, State, and local authorities, health care fraud convictions are up nearly 20 percent and the number of civil fraud cases increased by 61 percent.

A key element in our anti-fraud program, Mr. Chairman, as you mentioned, is Operation Restore Trust which was launched by President Clinton in 1995. And Texas has been in the forefront of making Operation Restore Trust a success. Our Dallas office developed a strategy to have nurses who do home health quality reviews also look for fraud and abuse. These nurses have identified $33 million worth of inappropriate payments in Texas and the strategy is now being used nationwide.

With support from this committee and from all of you, the Balanced Budget Act provided several new tools to fight fraud and abuse. Now, Medicare can bar felons, require surety bond for home health agencies and other providers, impose penalties for services offered by providers who have been kicked out of Medicare and Medicaid, and require providers to give us their social security and employer identification numbers, so we can check for histories of fraud and abuse before we let them in the program.

One provision, closing a loophole that let home health agencies bill in high cost areas for services that were provided in low-cost areas, will alone save us millions of dollars. This was a particular problem in Texas with differences between rural and urban areas

and how much it cost to provide home health care. And that's something that we discovered through Operation Restore Trust.

We are also targeting durable medical equipment fraud which is one of the subjects of your hearing today. Like home health agencies, we are requiring DME suppliers to obtain bonds. We are banning telemarketing by DME suppliers, requiring them to have a real office and a working business phone at that location, instituting civil and criminal sanctions for false information on billing member applications, and based on a recommendation from our colleagues in the Office of the Inspector General, we are now conducting and requiring site visits of all DME suppliers.

One of the fast growing areas of fraud and abuse and one that we particularly noticed in Texas, is community mental health centers, where care is being rendered to beneficiaries who are not mentally ill, or by unqualified, unlicensed staff. We are targeting this problem in nine key States including Texas and Arkansas, with onsite reviews of all centers in these States.

Texas has around 150 community mental health centers and we spent $32 million on so-called partial hospitalization benefits in 1996. For 1997, it looks like that's going to have doubled. In January as a result of looking at these numbers, we started reviews and so far, looking at 45 of the centers in Texas, we found 80 percent of them don't qualify under the program. And in the 1999 budget, Mr. Chairman, we have three proposals to try to deal with this problem.

While we are making some good progress here, we can and we must do more, and I think that's why you are having this hearing. That is why the administration is also seeking new legislation to give us additional tools that we need to fight fraud, including authority to collect user fees from providers so we can do more audits; eliminate excessive reimbursement for drugs, which goes to the question that Congressman Coburn mentioned about incentives; eliminate and curb abuse of outpatient health benefits, which I just referred to; and bar providers from using bankruptcy to avoid paying back money they owe to Medicare.

Mr. Chairman, I know that you and Congressman Ganske and Congressman Coburn agree that we simply can't tolerate those who would cheat our beneficiaries and the taxpayers. And that is also why we are opening a new fraud office in New Orleans this spring. It is the latest step of the crackdown that we began in 1993, and it will operate in much the same way as our highly successful office in Miami to coordinate efforts among Federal and State officials, law enforcement, private insurance, and consumer advocacy groups. The new field office, I hope, will make major inroads against fraud and abuse throughout this region.

We are also working to develop a long-range strategy to fight fraud and abuse. And that is why in 2 weeks I will convene a national conference on fraud and abuse. We are inviting experts from many fields to share their experiences and help us identify the best practices in fighting fraud. Our goal is to learn everything we can in order to design an innovative and effective comprehensive plan that will help us stay a step ahead of those who would take advantage of taxpayers and our beneficiaries.

Fighting fraud is a top priority for me as I know it is for all of you. My tenure as HCFA Administrator will build, I hope, on the anti-fraud efforts initiated over the past few years and some of the new things that you have proposed to Congress. You have provided us with significant new tools in the Balanced Budget Act. Coupled with the President's new proposals, I think we'll have a strong new arsenal of weapons to remove bad actors from our rolls.

We are making progress, Mr. Chairman, and with your support, I know we can do even more. I look forward to working with you in our efforts to stamp out fraud and abuse. Thank you very much.

[The prepared statement of Hon. Nancy-Ann Min DeParle follows:]

PREPARED STATEMENT OF HON. NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Chairman Barton, thank you for convening this hearing today to talk about one of my highest priorities as Administrator: combating waste, fraud and abuse in Medicare. It is a pleasure to be in Texas, a state which has been a pioneer in the fight against health care fraud.

Medicare has literally changed what it means to be old or disabled and sick in America. Over its 32 years of existence, Medicare has provided access to health care coverage for almost 80 million Americans, many of whom who would otherwise have lacked access to any kind of health care. And very importantly, Medicare is coverage that cannot be lost as you get older or sicker, or if you lose your spouse. Medicare has helped keep many elderly out of poverty status and prevented American families from having to bear the full burden of health care costs for their elderly or disabled parents or relatives. When President Lyndon B. Johnson signed Medicare into law, he predicted that Medicare would "take its place beside Social Security and together they will form the twin pillars of protection upon which all our people can safely build their lives and their hopes."

President Johnson was right. Today, Medicare is serving over 2 million residents of Texas, and more than 39 million beneficiaries nationwide. In Texas, Medicare spends about $11 billion each year, providing the State's elderly and disabled with over 3 million days of hospital care; 2 million days of skilled nursing home care; some 25 million physician visits, and providing home health services to about 260 thousand beneficiaries.

We are already achieving record success in increasing fraud and abuse investigations, indictments, convictions, fines, penalties and restitutions. Last year, using new Health Insurance Portability and Accountability Act authorities, nearly $1 billion was returned to the Medicare Trust Fund, thanks to our partnership with the HHS Inspector General, Department of Justice and state and local authorities. Medicare alone saved an estimated $7.5 billion in FY 97—mostly by preventing inappropriate payments—through audits, medical reviews, and ensuring that Medicare does not pay for claims owed by private insurers. Health fraud convictions are up nearly 20 percent and the number of civil health fraud cases increased 61 percent.

ON-GOING ANTI-FRAUD INITIATIVES

Operation Restore Trust (Restore Trust), launched by President Clinton in May, 1995, was a two-year comprehensive anti-fraud initiative in five key states designed to test the success of several innovations in fighting fraud and abuse in Medicare. The initiative focused on three specific areas: home health agencies, nursing homes, and durable medical equipment services in California, Florida, Illinois, New York, and Texas.

During its two-year, five-state demonstration phase, Restore Trust accomplished measurable successes: identifying $23 in overpayments for every $1 spent looking at home health care, skilled nursing facilities and supplies of DME and identifying 2,700 fraudulent health care providers and entities who were excluded from doing business with Medicare and other federal and state health care programs. Because of its successes, in May 1997 Restore Trust was expanded to 12 additional states and all Medicare service areas.

ORT In Texas

Our Dallas Regional office developed an Operation Restore Trust management plan and has actively pursued fraudulent providers. The Dallas Office designed and implemented a number of projects aimed at reducing fraud, waste, and abuse in Medicare. One example is the Texas Home Health Survey initiative which proved to be one of the most successful in Restore Trust and has since been adopted as a fraud fighting tool by states across the country. As part of the project, the Dallas Office used existing relationships with the Texas Department of Health to have registered nurses conduct claims reviews as part of their regular quality of care reviews in home health agencies. Nurses, who visited home health agencies were given a sample of claims billed by the agencies and paid by Medicare. The nurses were asked to review those claims at the same time they surveyed the quality of care provided by the agency. The nurses looked for documentation to establish that all billed services were properly ordered and provided and that Medicare coverage requirements were met.

Since March 1995, 83 Texas home health agencies have been reviewed under this project with just under $33 million identified in inappropriate Medicare payments. The most prevalent reasons that claims were denied were because the patients did not meet Medicare homebound requirements, or the services provided to patients were not medically necessary. The project objectives and methodologies were distributed throughout central and regional Restore Trust teams and soon became the model on which other regions developed their own projects to survey home health agencies.

In addition, Restore Trust in Texas made national policy recommendations which HCFA swiftly adopted including: developing a statement for home health agencies to certify their understanding of the Medicare homebound requirements and revising manual instructions to include the definition of homebound.

In 1997, the Dallas office initiated a project to review physical, occupational, and speech therapy claims paid by Medicare for patients in skilled nursing facilities. The project adopted the process used successfully in the home health agency projects by combining the resources of the State Health Departments, the Medicare contractors, and the HCFA Regional Office. The overall objective of the project was to use the State Health Department's onsite visit to review a sample of claims Medicare had paid. Nurses looked for documentation that the billed services had been properly ordered and provided and that the services were medically necessary. The Medicare contractor reviewed the nurses' information and began seeking repayment for these inappropriate billings. In 1997, this project identified over $400,000 of inappropriate payments made to skilled nursing facilities in Texas. In addition to recouping dollars, these types of projects prove the importance of partnerships between Federal and State partners to combat fraud, waste, and abuse.

Another Restore Trust project, directed by the HCFA's Dallas Office, identified inappropriate payments for durable medical equipment (DME) furnished to patients in nursing homes. All nursing homes in Texas are responsible for providing DME needed by their patients because payment is considered to be included in the rate paid to the nursing home. In cooperation with the State Medicaid Agency, and the Medicare contractor which processes DME claims, we were able to do identify separately filed and paid DME claims for nursing home residents for both Medicare and Medicaid. The project identified $1.5 million in overpayments which has been recovered from the DME companies.

Anti-Fraud Initiatives in Oklahoma, Louisiana and Arkansas

Building on lessons learned in Texas, our Dallas Regional Office has formulated fraud management plans for Oklahoma, Louisiana, and Arkansas where we have continued to crack down on those who wrongly take monies from Medicare. In Oklahoma, nurses from the State Health Department paid visits to 24 home health agencies last year where they uncovered just under $1 million in Medicare overpayments. Working in conjunction with HCFA, nurses from State Health Departments visited skilled nursing facilities in Oklahoma, Louisiana and Arkansas to verify that speech, physical and occupation therapies that had been billed to Medicare were in fact provided and had been correctly billed. The nurses identified over $1 million that was inappropriately billed to Medicare.

Working in partnership with the HHS Inspector General, the Department of Justice, and state and local authorities, we are achieving record successes in increasing fraud and abuse investigations, indictments, convictions, fines, penalties, and restitutions. Our regional offices have been leaders in uncovering schemes used to steal from Medicare and developing initiatives for fighting them. In fact, the efforts of these men and women on the front lines have borne fruit in recent legislation, regulations, or other initiatives.

THE BBA AND RECENT INITIATIVES

With the support of many members of this committee, the Balanced Budget Act made the most significant changes in Medicare and Medicaid since they were enacted more than 30 years ago. We're already putting in place significant new tools to fight fraud, waste and abuse.

Among these are the authority to: bar felons from participating in Medicare, require a surety bond of at least $50,000 for home health agencies, durable medical equipment suppliers, and certified rehabilitation facilities, impose penalties for services offered by a provider who has been excluded by Medicare and Medicaid, impose penalties for hospitals who contract with providers who have been excluded from Medicare, require home health agencies to bill from the place the service was provided rather than from a more expensive central office and require health care providers applying to participate in Medicare to provide their Social Security numbers and their employer identification numbers so HCFA can check an applicant's history.

We estimate that a single provisions in the Balanced Budget Act which closes a loophole that allows home health agencies to bill in high cost areas will save the Medicare program millions of dollars in the state of Texas alone. A home health agency currently based in a metropolitan area of South Central Texas provides services to thousands of Medicare beneficiaries throughout that part of the state. Medicare reimbursement rates are driven by the cost of doing business in that community so reimbursements are much higher in metropolitan areas than in rural communities.

Although many of the Medicare beneficiaries are served by satellite offices of the home health agency in rural areas where the reimbursement rates for their services are much less, the company bills the services from the metropolitan office where the reimbursement rates are much higher. The Balanced Budget Act requires Medicare to pay for home health services based on where the service was provided rather than where the parent office of the home health agency is located. By closing this loophole, we estimate that Medicare will pay $1 million dollars less for home health services in this one instance.

Home Health Initiatives

Over the last several months we have taken steps to make it tougher for home health agencies to enter and remain in the Medicare program. On September 15, 1997 the President announced a moratorium on all new home health agencies entering the Medicare program until HCFA could implement a range of new rules and management tools designed to enhance oversight of home health agencies and ensure that new Medicare home health agencies are not "fly-by-night" or low quality providers.

The moratorium was lifted earlier this year with the publication of a regulation requiring all home health agencies that participate in Medicare to: obtain a surety bond of at least $50,000, reveal "related business interests" that often assist in fraudulent and abusive activities, and serve at least 10 patients before they are admitted to the Medicare program after their quality of care is reviewed. Instructions have been issued to state survey agencies requiring that they must verify a surety bond and directing them to ensure an home home health agency is serving its own patients and not those that have not been "borrowed" from an already certified home home health agency. Furthermore, later this year HCFA will issue regulations to require home home health agencies to re-enroll every three years,

DME Initiatives

Just last month we took additional steps to stop waste, fraud and abuse by illegitimate dealers of durable medical equipment (DME). HCFA has proposed a regulation to make it more difficult for unscrupulous DME suppliers to enter the Medicare program. Our goal is to make sure Medicare only does business with legitimate firms. In addition to clarifying the law requiring a surety bond of at least $50,000, durable medical equipment suppliers will be banned from DME telemarketing, be required to have a physical location and a working business phone at that location, be prohibited from reassigning supplier numbers, be held liable for criminal and civil sanctions for false information on billing number applications and will be required by regulation to re-enroll in Medicare every three years.

HCFA is also taking other actions to ensure that DME suppliers receiving Medicare billing numbers are legitimate. As the HHS IG has recommended, HCFA has begun requiring periodic training on billing procedures for new and existing suppliers and has modified the DME application form to obtain additional information about prospective DME suppliers.

Community Mental Health Center Initiatives

One of the newest and fast-growing areas of fraud and abuse has been associated with Community Mental Health Centers. In January, we began a new initiative to stop the growing amounts of fraud and abuse associated with partial hospitalization services rendered by these types of mental health centers. In the last four years, there has been a dramatic rise in the total reimbursements, the average payment per patient the number of mental health centers. Reviews conducted jointly with the HHS IG have revealed large scale amounts of fraud including services being rendered to beneficiaries who are not mentally ill by unqualified, unlicensed staff.

In an effort to ensure that only legitimate mental health centers are permitted to enter and remain in the program HCFA will conduct onsite reviews of all mental health centers in nine targeted States, including Texas and Arkansas. We will terminate the provider agreements of all entities that do not meet Medicare standards. If this initiative proves successful, each fiscal intermediary will conduct onsite reviews of all new mental health center applicants, stopping illegitimate entities from gaining entry to Medicare and defrauding the Trust Fund.

FY 99 President's Legislative Proposal and Other Initiatives

In January, the President unveiled a legislative package and several initiatives which give us new tools in our fight against Medicare fraud and abuse. The legislative proposals seek authority to collect a fee from providers in order to increase the number of audits, eliminate wasteful excessive reimbursement for certain drugs, eliminate abuse of Medicare's outpatient mental health benefits, and prevent providers from taking advantage of Medicare by declaring bankruptcy.

These proposals will allow us to stop some of the unscrupulous home health agencies who have setup shop in Texas. In the early 1990's, a home health agency moved to Texas from the Midwest and started saving large numbers of Medicare beneficiaries. HCFA soon became suspicious of their large billings and with the HHS IG initiated an audit which found that the agency had wrongly billed Medicare for $30 million. Before we could recoup these monies, the agency filed bankruptcy, discharging their debt and stopping our ability to recover these Medicare dollars.

The President also announced that HCFA has increased the number of on-site visits to DME suppliers. Operation Restore Trust initiatives have found many purported DME suppliers whose addresses are the sixth floor of a five story building or are only mail drops in places like laundromats and night clubs. Site visits to two thousand suppliers in five states with the most DME fraud problems resulted in 650 suppliers being cited or rejected by Medicare in FY 1997. Site visits began in an additional 10 states this month and will be expanded nationwide. These measures will make it more difficult for unscrupulous suppliers to enter the Medicare program.

Additionally, the President announced an unprecedented effort to involve Medicare beneficiaries in identifying waste, fraud and abuse. Over the next few months the Medicare toll-free fraud hotline—1-800-HMS-TIPS—will appear on the statements beneficiaries receive listing the services that have been billed to Medicare on their behalf. Later this year, provisions in HIPAA will be implemented to give beneficiaries rewards for reporting fraud.

We simply cannot tolerate those who would cheat our beneficiaries and the taxpayers. That is why just last month I announced that Medicare will open an office in New Orleans that will coordinate anti-fraud activities in Louisiana. The New Orleans field office will open this spring. It's the latest step of the crackdown that President Clinton began in 1993. It will operate in the same way as our highly successful office in Miami. Medicare staff, based in New Orleans, will coordinate efforts among federal and state officials, law enforcement, private insurance and consumer advocacy groups. Working together, we will do an even better job of finding, prosecuting and preventing fraud and abuse.

Our experience with the Miami field office proved that onsite presence makes a considerable difference in raising public awareness of the Medicare fraud and abuse problems. The Miami office helped detect new types of fraud and proposed steps to stop it. We expect that this new field office too will make major inroads against fraud and abuse here in this region. Medicare beneficiaries of today and tomorrow deserve no less.

In the very near future, HCFA will publish a proposed rule which will allow us more flexibility in contracting with companies who can provide valuable services in the fight against waste, fraud and abuse. The Health Care Portability and Accountability Act provided HCFA with new authority to contract with private organizations to perform program safeguard activities like audits and site visits. We hope to start enlisting these private entities by the end of the year.

National Conference to Identify Best Practices

In a few weeks, I will be convening a national conference to identify best practices in fighting waste, fraud and abuse. This conference will bring together about 200 representatives of private industry, law enforcement, health care providers, and beneficiaries to discuss what is being done to combat problems like credit card fraud, insurance fraud, and telecommunications fraud in addition to health care fraud. Representatives from our Regional Offices will also be present and following the conference will help design a long-range plan to guide the agency in fighting and preventing fraud, waste and abuse.

CONCLUSION

We have stopped a great deal of unscrupulous dealings over the last 4 years. However, the nature of health care fraud demands that we must continuously identify new measures in order to stay a step ahead of those whose intention is to misuse Medicare Trust Fund dollars. Each Medicare dollar spent fraudulently is a direct drain on the resources which provide health care for our nation's seniors. I hope to build on the growing momentum to ensure that Medicare Trust Fund remains solvent for generations to come.

As I said in my confirmation hearing, fighting fraud is a top priority for me. My tenure as HCFA Administrator will build upon the anti-fraud and abuse efforts that have already been initiated under the Clinton Administration. The Congress has provided the Administration with significant new tools in HIPAA and the BBA. Coupled with a number of new legislative proposals we are requesting for FY 99, we believe we have a strong new arsenal to remove bad actors from our rolls. I look forward to working with you in our efforts to stamp out fraud and abuse.

Mr. BARTON. Thank you. I thought when I gave you such time as you may consume, that you were going to consume more time. So you caught me preparing my questions. The chairman is going to recognize himself for the first 10 minutes of questions and then we will go to Dr. Ganske and then Dr. Coburn.

Again, I want to commend you for coming to Texas for our field hearing. As I pointed out in my opening statement, when you've got a program that is spending over $200 billion, according to an audit last year, 14 percent of that is spent not on health care, so that is $23 billion. We need to focus on this issue, and to your credit, you are.

One of the things that I did in last year's Balanced Budget Act was put in a provision, that was put into the law, that requires the Secretary of Health and Human Services to come up with a pilot program for competitive bidding of durable medical equipment. In our next panel, we are going to have a gentleman who is a durable medical equipment provider talk about some of the possible abuses in the current systems.

Have you had any interaction at all with Secretary Shalala about beginning to put together this pilot program for competitive bidding?

Ms. DEPARLE. I certainly have. We did a briefing for her back in early January about our plans on it. She was very clear with me that she wants us to move ahead as quickly as we can on this competitive bidding demonstration, although there were a couple of steps that she wanted us to take before we actually announce it. One is to make sure that we briefed the Members of Congress in the areas that have been selected for this demonstration so that they're not surprised when they start getting calls about it.

Second, she wanted to be sure that we had a process in place to notify beneficiaries, because one thing that we have experienced in the past when we have tried to do some different things is that, you know, misinformation gets out, beneficiaries aren't sure what's

going to happen, they get scared that they are going to lose their benefits somehow. And that is not what this is all about.

As you know, the whole idea is to see whether or not Medicare could go out there and try to look for the best price for the services that its beneficiaries need. We have not been able to do that. Under law, there are prices that we are required to pay. And that means that the Medicare program is paying for oxygen, for example, 2 or 3 times what the Veterans' Administration is paying for oxygen for its beneficiaries.

Mr. BARTON. Right.

Ms. DEPARLE. That is just not right, and it is not something that I can defend or you can defend. So, Secretary Shalala wanted us to be sure that we had a system in place to notify beneficiaries to make sure they were aware of what was happening before we went forward. I think we are going to be ready very soon. I hesitate to give a date because every time I do, I turn out to be wrong, but I would say when it starts looking this pretty in Washington, we will be talking about it.

Mr. BARTON. Okay. I am sure you and I will be talking about it.

Ms. DEPARLE. We will be. We will be.

Mr. BARTON. Before it goes public. Another thing that I would like for you to address is also in the Balanced Budget Act from last summer which is the surety bond requirement for home health care providers. Here in Texas, it is been almost impossible, even for the excellent home health care providers, to get a bonding company willing to post bond. You are going to hear testimony later from one of those agencies about how difficult that has been.

Could you address the $50,000 or 15 percent of a home health agency's annual billing requirement and could you also comment on whether any thoughts have been given to allow a review of the past records so that the home health care providers that have never had a problem perhaps wouldn't have to post quite so high of a surety bond?

Ms. DEPARLE. To just set the context a little bit, the reason why we have focused so much on home health in Operation Restore Trust, is because it is a benefit that over the past 6 or 7 years has been growing at a rate above 25 percent a year. And it is now at a point where we are spending about $17 billion a year on home health services. The number of services and visits per beneficiary has more than doubled in a several-year period.

There were lots of indications that the reasons for this growth were not all driven by the needs of beneficiaries. And, in fact, I think you made reference to two studies that have been done in the past couple of years by the Inspector General and one by the General Accounting Office. The Inspector General looked at, I think, five States including Texas and looked at the home health billings and concluded that about 40 percent of them were inappropriate, which I know from discussions with you is not acceptable to you and it is not acceptable to me.

So what we were trying to do with the surety bond requirement is to have some more requirements so that agencies who get into this business will be able to pay back Medicare should they get overpayments or should they have an instance of fraud or abuse. And also it has been shown that the surety bond will help to deter

those who are just wanting to get into Medicare to rip it off from actually getting into the system.

Frankly, there weren't really any requirements or any hurdles that you had to meet at all. The new surety bond requirement went into effect January 1, we published around January 1, to announce the new surety bond requirement. Soon thereafter in talking to home health agencies and to surety bonds folks around the country, we discovered that there needed to be some clarification of our regulation, because it wasn't clear that the liability was limited to a certain period. Some of the surety bond companies were seeing it as an open-ended liability. And there were problems and you, yourself, called me about that to make sure I was aware that you were hearing the problems down here in Texas.

So we announced that we were going to postpone the requirement and that home health agencies should request an extension. There are a number of home health companies who have actually been successful in getting surety bonds and it does seem like there maybe——

Mr. BARTON. Are you aware of anyone in Texas or Oklahoma, for example?

Ms. DEPARLE. I am not aware of Oklahoma, but our—one of our regional people did tell me that there were over several hundred. I don't remember the number in Texas, but several hundred. I think there are 1,300 or 1,400 home health agencies in Texas. So I think a couple of hundred, maybe, have gotten surety bonds, that is what I remember hearing a week or so ago.

But in any case, we have postponed the requirement for basically 60 days to make sure that we can clarify the requirements for the surety bonds and get the word out there so that folks won't have so much trouble. I should say, though, that there are going to be some companies who will not be able to get surety bonds. And the reason is that, as was the experience in Florida which has instituted this requirement on a State basis, there are some companies, when you look at their records and their backgrounds, that a surety bond business will decide is too risky of a situation. Maybe they've had a lot of overpayments, maybe there have been some abuse problems in the past. So we don't expect it to be the kind of thing that a reputable agency would have a problem getting and we want to continue to work with you and your committee on making sure that that happens.

Mr. BARTON. Well, that is something we are going to have an ongoing dialog on because again, I support and I think the majority of Congress supports that there needs to be some financial accountability. But we don't want to make it so restrictive that home health care providers that have never had a bad audit or never had a problem end up not getting a bond or going out of business. We don't want to leave the fly by-night people in business and——

Ms. DEPARLE. No.

Mr. BARTON. [continuing] drive the good ones out.

Ms. DEPARLE. That is not the intent.

Mr. BARTON. I have got time for one more question, I believe. The Commission on the Future of Medicare is scheduled to meet for the first time next month or this month. Could you discuss how

you plan to interact with the Commission to help develop ways to strengthen and improve Medicare for the years ahead?

Ms. DEPARLE. Yes, sir. We look forward to working with the commission and providing technical assistance and analysis and support in any way we can. We frankly have our plates full at the Health Care Financing Administration right now, not only with trying to do better on fighting fraud, waste, and abuse, but just implementing all of the different provisions of the Balanced Budget Act.

And I feel like that has to be my top priority because in enacting the Balanced Budget Act, you extended the solvency of the Medicare trust fund by 10 years, which is a very significant achievement and it is against that backdrop that the Commission has the breathing room to do the kind of work that it needs to do. But we have to make good on the promise of extending the solvency of the trust fund. If we don't get the provisions of the BBA enacted, you know, it won't be there. So I feel like that has to be our first priority. But I stand ready to work with Congressman Ganske and his colleagues on the Commission in any way that we can and especially in providing analysis and data about Medicare and its programs.

Mr. BARTON. I think my time is about to expire, so I am going to recognize Dr. Ganske for 10 minutes.

Mr. GANSKE. Thank you, Mr. Chairman. Administrator DeParle, I am going to read you three or four letters which are typical of letters that Congressmen and Congresswomen are receiving on the issue of home health care and the blood drawing provision that Congress passed last year. And then I would like to hear a response and your explanation for the reason for the provision that was in the Balanced Budget Act on Medicare related to home health care and venipuncture.

Okay. Here are a couple of the typical letters. I have received letters like this. There has been a nationwide effort by the National Association for Home Care on this issue. I think this is something that everyone here needs to listen to.

An 82-year-old male—these are cases where it has been alleged that changes in the home health care will present senior citizens from getting care. Here is an example. An 82-year-old male who has undergone surgery for hip fracture and is confined to his bed or chair because of the surgery and severe rheumatoid arthritis. The patient is on anticoagulant therapy and requires regular monitoring of his blood clotting levels to prevent excessive blood clotting or hemorrhaging. It is alleged that our change in law would prevent that person from getting home health care.

A 75-year-old female with a long-standing seizure disorder and severe, chronic, obstructive pulmonary disease who is unable to leave home due to the inability to ambulate five feet without severe shortness of the breath. She requires regular monitoring of her blood to ensure that seizure medication is within a therapeutic range.

A 78-year-old woman with diabetes, high blood pressure, peripheral neuropathy in her hands, a below-knee amputation of her right leg, and diabetic retinopathy which has left her virtually blind. A person who is unable to prepare her insulin syringes, al-

though she can administer the medication once it is prepared. Her physician orders venipuncture for hemoglobin AC to give the physician overview of hypoglycemic therapy.

I can go on and on with letters that Congressmen have received just like these, where constituents are writing in to Congress calling for a change in our provision related to venipuncture. I am going to give you a chance to respond to this type of letter.

Ms. DEPARLE. Well, Congressman, as I think your question sort of suggests, it seems as though there has been a misinformation campaign going on to try to scare some beneficiaries. The purpose of the provision in the Balanced Budget Act was to deal with the problem that the administration had found in the home health benefit, by concentrating on it through Operation Restore Trust.

And as I said before, the benefit has just grown 30 percent a year, sometimes even more than that, for the past few years. So we began to look at what this spending growth was all about and it turned out there were areas of the country where a lot of beneficiaries were getting a full array of home health services, you know, 7 days a week, things like that, you know, many hours a day when all they needed was to have their blood drawn. If a beneficiary needs to have his or her blood drawn, and they are a Medicare beneficiary, Medicare will pay for it. And Medicare will pay if they don't want to leave their homes or if the doctor doesn't think they can leave their home to get it drawn, then Medicare will pay for a laboratory to go out and take their blood.

But the issue is, can Medicare—can the taxpayers and the beneficiaries and the program and the trust fund support someone getting a full array of these home health services when all they really needed was to have their blood drawn? And the answer to that was, no. And the issue with each of the three examples you raised is, does that individual need some other sort of skilled service other than just having their blood drawn? And that is a determination that their physician should make. The physician is the one who is supposed to decide whether a beneficiary needs home health care and what services he or she needs.

And in the cases you mentioned, I can't remember all of the details, but certainly the woman who was a diabetic amputee and the woman who could only move five feet, that sounds to me as though it is the kind of a situation where the doctor would determine that it would be necessary for them to have other services. And they would probably qualify for benefits, home health benefits, other than just because they need venipuncture.

But if the examples are of someone who just needs their blood drawn once a week, then, no, Medicare will not pay for them to have a full array of home health services under the new law.

Mr. GANSKE. So in all of the examples that I gave you, it would be reasonable to assume that those patients would meet other criteria which would enable them to continue their home health care; is that correct?

Ms. DEPARLE. Yes, from what I heard, I would be able to make that assumption.

Mr. GANSKE. It is just that if the only thing that they need is a blood draw at home, that they would be excluded from the other aspects of home health care. HCFA would still provide the blood

draw, but not allow that as an entry into somebody coming into the home and cooking a meal for that patient?

Ms. DEPARLE. Right. Right.

Mr. GANSKE. Is that——

Ms. DEPARLE. So that Medicare would be paying, you know, $20 instead of several hundred dollars a day. That is right.

Mr. GANSKE. Have you been concerned that there has been misinformation that has been sent out to beneficiaries on this issue?

Ms. DEPARLE. Yes, I have. I have been very concerned. We get—I get letters, maybe not as many as you get, but I do get letters like that, and it really—it really distresses me to think that beneficiaries are being scared like this.

Mr. GANSKE. And what has been your response to that?

Ms. DEPARLE. One thing we have told them is to contact their doctors because, again, this benefit is not supposed to be directed or manipulated by the home health agency. This benefit is one where the doctor is supposed to be the one who decides if a beneficiary needs it and looks at them and decides what their plan of care is supposed to be.

So we have urged the beneficiaries to get in touch with their doctors if they are being told that they are going to lose benefits.

Mr. GANSKE. Have you been clear in your communication with the home health care agencies on this point?

Ms. DEPARLE. Yes, in fact, I wrote each of them a letter back in January telling them that putting out misinformation about this as well as about the new interim payment limits, was unfair and that if we got complaints about that happening, we would consider it to be an investigation that we would need to do that could result in termination of the agency, in fact.

Mr. GANSKE. Because it is been needlessly scaring a lot of senior citizens.

Ms. DEPARLE. Yes, sir.

Mr. GANSKE. All right. Let me move on to a different issue. I am concerned about the surety bond requirements for home health agencies. And I am hearing a lot from my home health care agencies and they've been told by their bond issuers that would have very, very high financial requirements in order to get those surety bonds. In fact, I think we will hear some testimony a little bit later that—that the surety bond the issuers are putting the costs so high that it would drive a lot of home health care agencies, which are very reputable home health care agencies, out of business. They just couldn't afford that.

Has there been a problem with the regulations that HCFA has sent out to those bond insurers that have led them to put unrealistically high premiums on those bonds and what has been the HCFA response to that?

Ms. DEPARLE. I think there were three technical problems with the regulation, the notice of proposed rulemaking that we put out, Congressman. And in talking to the surety bond folks and the association that represents the surety bond companies, they have said that they are eager to provide surety bonds. They are happy to have a new source of business, but they wanted to be clear on the extent of the liability.

The regulation itself didn't say that the liability would only extend through the period for which the bond was written and it didn't provide limits. So there were three technical things that were problems that really related to making clear what the extent of the liability was, and making clear that the surety bond company could appeal if there were an overpayment taken and things like that.

We have since given notice to all of the home health companies through the Federal Register that we intend to make a change in the regulations and then in the meantime, we are giving the agencies more time in which to obtain the bonds and to comment on the rate.

Mr. GANSKE. How much time are you giving the home health agencies?

Ms. DEPARLE. Well, we are going to be putting out the new information in the Federal Register, I think, within the next 30 days and then from that date they will have 60 more days in order to get the bonds. As I mentioned in response to the chairman's question, there are a number of home health agencies that have gotten bonds, and if they have, that is fine. Those who have not been able to, and one of those is here today and I have been speaking with her, they can submit evidence that they've been trying to get a bond and they will get an extension of time.

So we hope to be able to work with them to work out these problems and certainly it is not our intention to deter the good agencies from being in this business.

Mr. BARTON. Gentlemen, since time has expired, we will have a second round of questions for Ms. DeParle. The Chair now recognizes for 10 minutes, Congressman Coburn of Oklahoma.

Mr. COBURN. Thanks again for your testimony and thank you for being here. When Medicare Home Health was originally instituted, were purely custodial needs outside of medical needs a part of that program?

Ms. DEPARLE. Congressman, I don't know enough about the history of it. I do know that in 1989, there was a court case that quite dramatically changed any constraints that had been on that benefit in the past. I think HCFA had tried to put some limits on the number of visits and that kind of thing, and there was a court case that changed it.

And from looking at the legislative history, my understanding is that Congress didn't intend for it to be a long-term care type of benefit. It really was designed to make the hospital prospective payment system work. And the idea was, if we are going to limit the number of inpatient hospital days, then we need to provide something on an outpatient basis for medical reasons. So I don't think it was intended——

Mr. COBURN. Well, I have looked through and read all the history on it and the history was never intended for it to be purely custodial. That, in fact, it was intended to allow early discharge from hospital and prevent recurrent hospitalization on people who had severe illness. And what we saw was an expansion of custodial needs and that is—that is why the venipuncture issue is so pertinent because it is so profitable in that area.

Are there other cost plus programs presently that—that is in Medicare that the government is paying for SNF units, the durable medical equipment, hospice, are those cost plus programs?

Ms. DEPARLE. Well, yes, and we are moving toward prospective payments on all of those as a result of the Balanced Budget Act. Because I think you've all mentioned that the incentives are all wrong in paying on that basis. There is no incentive to contain costs on anyone's part. That is why I think Congress has agreed that we need to move in that direction.

Mr COBURN. Knowing that you were not at HCFA when a lot of this expanded, you stated a moment ago that there were no hurdles in place to limit those that might have come into the home health care industry and several of the other industry components in health. Why not?

Ms. DEPARLE. Well, you know, hindsight is 20/20, or whatever they say. I think perhaps there was a concern in the beginning of this about, will there be home health companies if we want to constrain inpatient hospitalization, since we have to have home health, and are we sure there will be home health companies? So that is one way of looking at it.

Perhaps there was concern about making sure there would be enough agencies to supply this service. And maybe people just weren't thinking as far ahead as they should have been. But I do know that it makes sense now to have requirements so that there is an initial capitalization. Previously, there was not even a requirement that a home health agency have served any number of patients before they get a Medicare provider number. That doesn't make sense to me to do business in that way, so we are moving in the direction of some more requirements.

Mr. COBURN. Are you aware of the 1995 law that was passed that says physicians are responsible both financially and ethically through Medicare for who is and is not eligible for home health care?

Ms. DEPARLE. Yes, sir, I am.

Mr COBURN. Do you know when the regulations on that law will be published?

Ms. DEPARLE. I believe this is the issue you raised with me at lunch a few weeks ago.

Mr. COBURN. I am not trying to embarrass you——

Ms. DEPARLE. No, I know.

Mr COBURN. I have asked this question of the Secretary of Health and Human Services and I am extremely frustrated because I think that if—if we are going to say that physicians are responsible, then we ought to hold the physicians responsible. We hold them responsible in every other aspect of health care except home health, and I am really interested in the process of developing the guidelines for that.

Ms. DEPARLE. I was not happy when you asked me that question at lunch because I don't have a good reason why a law that was enacted in 1995 wouldn't be a regulation now, yet. And I had hoped you were wrong, but I should have known better.

Mr. BARTON. You need to talk to my wife.

Ms. DEPARLE. I found out and I went back to ask afterwards, I said, "I hope he is wrong about that." They said, "No, he is not."

What I would like to do is get you an answer for the record about when we will have the rule out.

Mr. COBURN. I talked about incentives a minute ago. Can you envision a Medicare system in which Medicare makes no payment until authorized by the recipient of the service?

Ms. DEPARLE. Yes.

Mr. COBURN. If you envision such a system, can you see that that in itself alone might markedly curtail fraud and abuse in Medicare.

Ms. DEPARLE. Yes, I can. And this is an interesting area because one of the difficulties with—and, again, this relates to what you've all been saying about incentives, one of the difficulties with the way the system runs is that, we are required by law to pay all claims within 30 days. And what that does is, it leads to incentives to just get the payments out the door and not necessarily to look at them closely and to see what's really going on.

And, in fact, there is a gentleman named Malcolm Sparrow, a professor at Harvard, who writes on the subject of home health care fraud. He has even argued to me that he thinks that electronic billing leads to more fraud, waste, and abuse because it—it prevents an intelligent human being from looking at something and seeing the patterns in it.

I don't think we are ever going to go back to the days of only paper claims, and I am not encouraging that. But I do think you've touched on an interesting area which is that, because of the requirements that we pay so quickly, sometimes and without talking to beneficiaries you say, sometimes we may pay claims that we shouldn't, and we ought to explore where there are ways to get to that problem.

Mr. COBURN. Let me ask you another question then. Is it an obligation of every provider whether it is a physician, a hospital, home health durable medical equipment, that if they are asked by a Medicare recipient for a copy of their billing, is it not only their ethical obligation but also their obligation under the law to supply a copy of that to that recipient?

Ms. DEPARLE. I believe it is.

Mr. COBURN. Can you tell me whether or not you have had significant complaints in that regard to HCFA?

Ms. DEPARLE. About beneficiaries who want copies of their bills and can't get them?

Mr. COBURN. Right.

Ms. DEPARLE. I haven't seen significant complaints about that. I have from my own discussions with beneficiaries, I do believe that giving beneficiaries more information and letting them look at the bills is very important and we are now doing that. We are providing explanations of Medicare benefits to all beneficiaries.

And just last month, the Inspector General started putting their fraud and abuse hotline number on all of them and we are expecting to get lots more activity in that regard. What they tell me more often is that they were billed or Medicare was billed for a certain thing that they didn't get. And the other thing that was disturbing to me and I think it would be disturbing to you and to Congressman Ganske as health professionals, is that some beneficiaries tell me that they are afraid to say anything about it because they feel very vulnerable and they don't want to lose their doctor and make

him or her mad. So, that is another incentive we need to do some work on.

Mr. COBURN. But, again, if that was commonplace and somebody knew what Medicare was getting billed, and they had to sign off and say, you know, that is a reasonable fee for the service I just did or if that is exorbitant, there is no way my tax dollars should go for that. Remember, most Medicare recipients paid in a significant number of dollars and it is my contention if they knew what the services were costing, whether it is in my office or any other place, that they are going to be a better consumer of that—that health care.

I have one other thing, and you and I have talked about this, but I want to get it on the record. It is possible that as we look at these changes in home health care, that we are going to have to consider a mechanism for outlier reimbursement——

Ms. DEPARLE. That is right.

Mr COBURN. [continuing] for the prospective payment system. And would you comment on that because many of the quality home health firms in my district have been extremely concerned that they are either going to be in a position where they are forced to abandon their business or abandon the patient without that type of thing coming.

Ms. DEPARLE. Yes, I can comment generally. The prospective payment system is designed to encourage more efficiency by providing a capitated payment for—per beneficiary. And it should also, though, reflect the kind of risk of the individual beneficiary. And the problems that you are identifying is, there are some situations where a home health company, either because it is very good at dealing with higher risk patients or sicker patients or just by luck of the draw, happens to be the one that served a lot of the sicker patients, they could have a heavier caseload of those folks. And through no fault of their own not be able to be any more efficient in serving them just because they needed to spend a lot of time with those folks.

So what you have pointed out to me is that, the prospective payment system that we developed needs to be able to adjust for those situations and certainly that is the goal. We need to talk to you more as we move forward in developing this system, it is extremely complicated as you know. We will work with you on that.

Mr. COBURN. I believe I am going to turn it back to you at this point.

Mr. BARTON. That does conclude the first round. Ladies and gentlemen, you have just witnessed a historic first for this Congress. We have had the first testimony, the opening statement, and the first round in less than an hour. If we were in Washington, there would have been a journal vote about 10:10. We'd start at 10, there would be a journal vote at 10:10. That would take 30 minutes to go vote. We'd come back, there would probably be opening statements, and then there would be a parliamentary vote on the floor, which would be another 30 minutes and we'd come back. So what you have just witnessed would have probably taken 2 to 2½ hours. So we have done it in 55 minutes.

We are now going to start the second round of questions. We will give each member 10 minutes, they don't have to take the entire

time, but we do want to give an opportunity for one follow-up round. Dr. Ganske, for as much as 10 minutes.

Mr. GANSKE. Ms. DeParle, I am sure you are familiar with the U.S. News and World Report article on Medicare fraud and abuse.

Ms. DEPARLE. Unfortunately, I am.

Mr. GANSKE. The February 2 issue. And for those in the audience, if you have not yet seen this article, I would highly recommend it. This article describes nothing less than a booming health care fraud support industry. Teams of accountants, computer billers, check cashers, whose "no questions asked" work ethic greases the fraud skids in places like Miami.

"Finders will seek elderly people as patients for crooked clinics. These finders are then paid $300 for a patient with both a Medicare and a Medicaid number, $150 for just one number. And the finders in turn pay the patients between $75 and $150 for their help."

This article goes on to say that, "The practice has become so popular that many elderly people depend on the cash." In fact, I think you have set up a special fraud unit in Miami related to this. So I have a couple of questions.

In the Kennedy-Kassebaum Bill, HCFA may now hire outside companies to watch over its contractors. Previously, the law did not allow HCFA to do this. But more than a year after the law's adoption, HCFA has still not awarded any such contracts. I would like to you to comment on that.

And then, second, I would like you to comment on the fact that a lot of these abuse and fraud schemes rely on the fact that you are dealing with 30 some contractors across the country and there isn't a lot of communication between them. So that if you get a fraudulent company that then uses a finder and gets the Medicare beneficiary's number, they can bill in Miami, they can bill in Cleveland, they can bill in Seattle, they can bill multiple places on that number across the country. And it is my understanding that HCFA doesn't have a mechanism to know that you are getting billed for the same patient in multiple places across to country.

Now, HCFA looked at, before you came on board, getting a centralized computer data system to try to prevent that. I would like you to address that as the second part of the question.

Ms. DEPARLE. Okay. If I can take the second part first. The situation described in the U.S. News article was outrageous and I was outraged as I am sure you were in reading about the kinds of things some people will do to rip off the Medicare system. There is the organized crime ring that was identified in there and I don't want to leave the impression that U.S. News found it. We found it. HCFA and the Inspector General worked together and we found this organized crime ring working out of the New York area and they were billing us in several different areas.

Now, it is my understanding that we do have a way of finding folks who are doing that kind of thing, but it is cumbersome. It is called the common working file which is computer terminology for a software system where claims are all reported in, but it is cumbersome and it doesn't work as well as we would like. As you noted, HCFA had been in the process of developing a Medicare transaction system that would have consolidated all of this and

there would have been one system and it would have worked better.

And that idea is still a good idea, but the system itself and the development of it didn't go as planned and it was off in a ditch, and so when I came, I decided we should stop and re-look at it and decide which way to go, and not try to do something in a "big bang" kind of theory, since it was all going to come up at one time, but rather to do it more incrementally, so that is where we are right now.

The first part of your question——

Mr. GANSKE. Let me just interrupt for a minute. Do you have a timetable, I am not talking about having a centralized computer system that can handle everything in Medicare centrally. I am just talking about, can you have in a reasonable period of time a system whereby at least the numbers can be run through a central depository so that you can check and make sure you are not getting claims on the same patient from multiple parts of the country simultaneously? I mean, can you give us a timeframe when—when you think it would be possible for HCFA to come up with such a system?

Ms. DEPARLE. I don't want to do that today, Congressman, but I will be happy to provide an answer for the record about that. I should say, though, our first priority for the next year has got to be to make sure that our systems are Millennium compliant, which means getting the computers so that they'll be able to operate on January 1, 2000.

We didn't get an early enough start on that in my opinion. There's a lot of work that has to be done precisely for the reason that you pointed out, that we have all these different contractors around the country. And each one of their systems has to be Millennium compliant unless Congressman Coburn gets the law changed so we don't have to pay them all within 30 days.

But as it is right now, unless we have them ready for the year 2000, we won't be able to pay claims. So that's the No. 1 priority right now. But I want to get you a better answer on when we can have an improvement to the system so that we can track the claims coming in from different—various parts of the country.

Mr. GANSKE. Okay. If we don't have the central computer read, and I understand the Millennium problem——

Ms. DEPARLE. Right.

Mr. GANSKE. [continuing] is a big one, it should have been worked on a few years ago. Why not—why not take that authority that you got from the portability bill and use some private contractors to do this?

Ms. DEPARLE. Well, I think that is part of the answer actually in Medicare and technical programs. Frankly, that regulation wasn't as far along as it should have been when I got there and I've said that it's a priority. In fact, I think it's in the Secretary's office right now waiting to be signed off on, to be put out so that we can begin using some other contractors to do Medicare program integrity functions, and I think that will help make a difference in this.

Mr. GANSKE. So Secretary Shalala currently has on her desk——

Ms. DEPARLE. Yes. And I shouldn't say she has it on her desk. When I say the Office of the Secretary, I mean, you know, the various Assistant Secretaries who work with her, but, yes, it's there. It's just about ready to go. We're working with the Inspector General. The Inspector General's Office had a few technical comments about it, but it's just about ready to go. And I don't think we got it done quickly enough so let me say that right up front, but now my goal is to get it out as quick as I can.

Mr. GANSKE. So, are you looking at being able to get some contracts—some private contracts on this within the next couple of months?

Ms. DEPARLE. No, sir. That was my question when I reviewed this back in December. It takes longer than that to do a bid—this would be a bidding situation, I think, and I think it will take longer than that. I'm pushing to have something done by the end of this fiscal year or the beginning of next fiscal year. I know that seems like a long time, but I've been told that to get a contractor on board takes that long. I guess it doesn't in Texas, Mr. Chairman, but in Washington, I'm sorry, it does.

Mr. BARTON. We'll help you speed up the process.

Ms. DEPARLE. It will help that you asked about it because I'll go back and ask again, but it seems to take a while.

Mr. GANSKE. How big a problem do you think is this problem with laundering drug money and Medicare?

Ms. DEPARLE. I wouldn't want to speculate on it and I don't have any real evidence of how big a problem it is. Even one example like that makes me very angry as a taxpayer, much less as the person who's running this program. You know, we're doing some things that should make a difference.

One of them is in the durable medical equipment business, which is what these people were involved in, there are basically no requirements to get into the business. We've been talking a lot about surety bonds in the home health area, but we also are going to require surety bonds for the durable medical equipment. That regulation went out the first of January.

Mr. GANSKE. Well——

Ms. DEPARLE. We're also going to require something simple. This, you know, this seems silly, but I doubt anyone here in this building would do business with someone they've never seen before.

Mr. GANSKE. I think you should——

Ms. DEPARLE. And in Medicare we've been doing that. We have not done site visits to see if these durable medical equipment suppliers actually exist. And the frightening thing is that we had examples of plenty of them that were billing us that didn't exist. So now we're going to go out and eyeball them and make sure they're there before we start doing business with them. I think that will make a difference, but I'm sorry I don't have an answer for you about the organized crime. Perhaps Mr. Coggins or someone from the Inspector General's office would be in a better place to give you an answer on that.

Mr. GANSKE. Mr. Chairman, I think this an example of why something that sounds sort of esoteric like requiring a surety bond for durable medical equipment, it's not so esoteric because what we've had are examples where without requirements for legitimacy,

if you truly have a legitimate medical equipment supplier in the absence of that, it opens up this tremendous potential for illegal criminal activities in this system.

And so, while I think we need to work out the surety bond issues, in terms of making sure that you—that the home health care agencies require durable medical equipment agencies to get their bond, there was a reason for that being put into law.

Mr. BARTON. Thank you. Excellent questions. Chairman Coburn.

Mr. COBURN. I do want to make a statement for the record that's been referred to is the prolongation of the part A trust fund for 10 years. But nobody should be happy about that because all we did was move several hundred million—billion—million dollars from one program to the other pocket from which you're taxes are going to pay for it in the general fund by shifting from part A to part B. We're still going to spend the same money, we're just going to spend it out of a different part of your wallet. So there are no savings associated with that other than the fact that it decreases time and it's an accounting trick. There's no change in that effect on the Federal Government, the dollars, or anything else.

I just—I want to make one other comment on home health care. I'm from Oklahoma. I'm very familiar with it. Oklahoma is the second worst in terms of overutilization of home health care dollars in the country behind Louisiana. And where the national average is 70, Oklahoma is around 120 visits per person, per year.

What that says about Oklahoma is that we're really a poorly placed, a bad place to live and it's really a risk for your environment if there's a lot of fraud, and basically there's a lot of fraud in home health in Oklahoma. That's not to say we don't have an excellent unit of sincere caring people who want to care for our senior citizens and they've been tarnished and tainted by those who have been opportunists in this poorly designed system. And there's no excuse for it, it's a typical Federal program that is very poorly designed that has caused a tremendous amount of waste.

Mr. BARTON. Before we jump on Louisiana and Oklahoma, Texas is number 3 at 116.

Mr. COBURN. Well, we're right in the thick of it anyway. I said all of that to say, that it is refreshing to me to deal with the new administrator for HCFA. I sense an honest desire to meet provider's needs, to care for the seniors in this country, and try to take an agency that has an impossible job. It is impossible for HCFA to do which we've asked them to do until we change the requirements and the set up under which we're going to manage Medicare and Medicaid in this country.

And I just want to tell you, I appreciate your straightforwardness, your forthrightness, and the attitude that you have that you're willing to work on the problems that are before us and not give up. And I just want to encourage you to keep that as you—as you dig into in this pile of alligators that you're about to be with, don't lose that. In fact, we can change this. We can fix this program, we can make it where it's not 20 percent fraud. We can make it where it responds to the needs of the people in this country and I just want to thank you for coming down here. I think it says a lot.

I also will tell you that the Administrator has agreed to come to Oklahoma, not for a hearing, but to come visit with hospitals, doctors, home health, to come see in my home community the problems these providers have in working with HCFA and Medicare so she can see it from the other side. And to me that says that we have somebody that really has our best interest for our whole country and our seniors, No. 1, and I thank you for it.

Ms. DEPARLE. Thank you, Congressman.

Mr. BARTON. We ought to make sure we have that on tape, because Dr. Coburn doesn't usually compliment people. At least to the chairman he doesn't, I'll put it that way.

Before I ask my questions, it doesn't automatically follow that because you have a large number of visits per patient, per year that the system is being abused. But Louisiana is No. 1, Oklahoma No. 2, and Texas No. 3. The State that has the least number of visits is Iowa and Dr. Ganske could have pointed that out on the record, and he didn't do that.

I'm going to recognize myself for the last 10 minutes and I don't think I'll take the entire 10 minutes. We've been focusing so far on some of the current problems in Medicare and I think both Dr. Coburn and Dr. Ganske have highlighted those. Let's focus on the future. This subcommittee is not only about finding problems, it's about finding solutions.

Right now we're changing from the open-ended reimbursement cost base system, we are moving to an interim payment system for home health care and then we're going to go to a prospective payment system beginning in 1999. Would you talk a little bit about the interim system and then also the PPS system that we're going to next year?

Ms. DEPARLE. Sure. The interim system, which goes into effect in April, has already been announced and is designed to try to create some incentives in this transition between what's really been an open-ended reimbursement system to the prospective payment system which would be capitated. And the transition is supposed to curtail payments on an aggregate-per-beneficiary basis so that for each home health company, they will be given an amount of money that is based on their caseload from a couple of years ago. Then they will be asked to manage that money among their different beneficiaries, so that if they have sicker beneficiaries and those who are not as sick, they should be able to spread the costs among those folks. And in that way it's a transition to the capitated system.

And, you know, there should be some savings from that. It should also be a way of becoming more efficient as we move to a prospective payment which will be in a couple of years.

Mr. BARTON. Now, there's been a pilot program on this and I know there are some home health care providers in Texas that are under that pilot program. Is there anything you can say on the record today based on pilot programs about the success of going to a PPS system? Is there enough data that you can say that we expect to save "X" percentage of dollars or anything like that?

Ms. DEPARLE. I don't have the numbers here at my fingertips, Mr. Chairman, although I do understand that the demonstration has been successful and, in fact, I was just reading a letter the

other day from a home health company that was part of that demonstration. It felt like it was a success for them in managing the dollars more efficiently.

So I do know sometimes, I think we in Washington are guilty of holding the new thing or the new program to a higher standard than we held the old program. I think we have to remember that the old program had incentives in all of the wrong places for encouraging efficient care and making sure that we're using the taxpayers' dollars wisely. I think what we've just done in the Balanced Budget Act, while it's going to be complicated and we're in that difficult, painful phase of trying to implement it now, I think in a few years we're going to look back and be glad we did it because I think it is going to be better for the Medicare program.

Mr. BARTON. Now, is there going to be quite a bit of input allowed from the provider community in setting these what I would call the DRG, diagnostic related group rate, or the relative value rate, have you gotten the committees——

Ms. DEPARLE. Yes.

Mr. BARTON. [continuing] and the local providers?

Ms. DEPARLE. Yes, not only is there going to be input allowed, but, in fact, we're having Congress mandate that we collect data from the home health agencies as we set this program up about their costs and how they're doing it. And we're trying to determine what the appropriate length of care is and all of that, so there is going to be a lot of input from all of the agencies. And then in Washington, we meet on a regular basis with the different associations and, you know, basically anybody that wants to meet with us can certainly get their input to this.

Mr. BARTON. And there will be public notices and things of this sort?

Ms. DEPARLE. There sure will be.

Mr. BARTON. You know, we've focused pretty much on home health care and durable medical equipment, but the Balanced Budget Act also had some provisions for doctors in hospitals organizing what's called a PSO. Could you give us a very quick update on the regulations that HCFA is putting in place for these PSO's to be set up under Medicare?

Ms. DEPARLE. I sure can. And this is another piece of good news, I think, for our beneficiaries because what it allows is a new type of health plan to be available for Medicare beneficiaries from a provider-sponsored organization. This will be different from a traditional HMO in that it is not like an insurance company, it's more like a group of providers that get together to form a network.

Congress mandated that we develop the regulations for these new provider-sponsored organizations and the Medicare and Choice plans through negotiated rule making. And I have to tell you that when I first got to HCFA, the prospect of negotiating rulemaking really struck terror in all the hearts of all of the bureaucrats at HCFA because it was not something that they were very familiar with. But we're now almost through with the process and the folks who have participated in it, both from HCFA and from the outside from the American Medical Association, the American Hospital Association, various other groups, have all said that it's been a productive process.

I think the rule—I think one of the rules is supposed to be announced in April for the new provider-sponsored organizations and the other one is supposed to come out in either June or July. And right now it seems that we're on track to achieve those two deadlines.

Mr. BARTON. This is my final question. And, again, this goes to the theory of the way we're trying to operate the subcommittee this year. Which is, instead of being confrontational we want to work in a cooperative fashion to find solutions because Medicare waste, fraud, and abuse is everybody's problem. It's not a political problem. It's not a regional problem.

Is there anything that the Congress could do in terms of legislation to give authority or take away authority to make it easier to combat waste, fraud, and abuse that you'd like to recommend at this point in time? Do you have any proposed solutions you'd like to put on the table?

Ms. DEPARLE. I sure do. And I'll talk about a couple of them, both of which are in the President's budget which is up before your committee right now. One deals with the problem of how we pay for certain drugs that Medicare pays for. As you know, we don't cover drugs in general, but we do pay for certain things that are administered by physicians and through durable medical equipment. And I think later on today we're going to be hearing about one of those problems and it's a situation again where, as you all have said, the incentives are in the wrong place because of the way we pay for it.

We pay what's called the average wholesale price which turns out to be a lot more than what any other payer in the marketplace would really pay. And that creates incentives for bad things to happen. I don't want to spoil the rest of this afternoon's testimony, but I believe if we had the authority to pay differently, which we've requested in the Balanced Budget Act, and I think we didn't get all the way there in the BBA. We'd like to revisit that with you and your colleagues and see if we can make some progress there.

The other thing is that, frankly, Mr. Chairman, we need more resources. You have said to me a number of times that you think we need to do a better job in the prepayment side of this, and we've talked about COTS, and we've engaged in some constructive discussions on how to move forward there, before we pay a claim to make sure it's a good claim.

However, one reason why we've had the growth that we've had and the problems that we've had is, as Medicare has grown. Where we now have 900 million claims a year, the number of claims that we audit and that we do focus medical reviews on has not grown. In fact, it has declined. And one of my people back at HCFA who works on home health told me that until the late 1980's, he said, "We used to review every claim." And he said, "Now when the home health care claims come in the door, we just wave at them as the payments go out."

So we need to refocus and talk about how people pay for these. We need to devote more resources to audits and to focus on medical reviews and maybe some day while you and I are here, we'll get to a system where we don't have to spend so much on the back end, but right now we need to do that.

We're asking this year for some user fees and some provider enrollment fees that will help us to double the number of audits that we conduct. And I think that if Congress can see its way clear to give us that authority and that ability to collect the user fees, that that would help a great deal here.

Mr. BARTON. Well, Dr. Coburn has pointed out that if we can work together to change the incentives so that we create disincentives for fraudulent billings that the amount of resources necessarily may not be as high.

Ms. DEPARLE. That would be great. And I hope in 4 or 5 years we won't need to spend as much on audits. I really do, but my personal view is right now, you know, it's gotten to the point where I'm sorry to say it, but we have to look at some resources.

Mr. BARTON. I understand. We want to thank you for your testimony. There will be additional questions for the record. There are a number of members of the subcommittee that are not here. We'll keep the record open and give them an opportunity to provide questions in writing and give you an adequate opportunity to provide answers back in writing.

Again, I want to commend you from coming down from Washington. This is a big, big problem. I personally wouldn't want to have your job. I'd hate to go to bed at night knowing that I'm responsible for $200 billion being spent very effectively for health care for senior citizens. But you're to be complimented for being open and willing to work with the Congress.

Ms. DEPARLE. Thank you. And thank you all for your commitment to this issue.

Mr. BARTON. We'd now like to have our second panel come forward. And as you come forward, we're going to try to get your name tags set up. We have here Mr. Robert Richardson, the Inspector General for Criminal Investigations, the Office of the Inspector General in Washington, D.C. He's going to be accompanied by Martin Campbell, who is the Assistant Inspector General for Criminal Investigations in the Dallas region. We're going to have Mr. Donald Chrysler, who is the Chief Executive Officer for Pro Med Pharmacies, Incorporated, in Amarillo, Texas. He'll be accompanied by Jeff Baird. We're going to have Ms. Claudia Foster, who is the Administrator of Associated Home Health Care in Waxahachie, Texas. We're going to have Dr. Bohn Allen, who is a physician in Tarrant County who is representing the Texas Medical Association.

The subcommittee will come to order. Our panelists, you may proceed. We'll reconvene. We'd like to welcome our second panel to the subcommittee. We're going to start from my left to right and just work our way down. Each of your written statements will be submitted in its entirety for the record and then we'll ask that you summarize your written testimony in approximately 5 minutes. We're not going to shoot you if it takes a little bit longer, but that is a general guideline.

We do take all testimony under oath. Is everyone on the panel willing to testify under oath?

You also have the right to be advised by counsel or any other technical witnesses or technical assistance during your testimony.

Is there anybody here that thinks that you're going to need counsel or technical assistance? Ms. Foster.

Ms. FOSTER. Yes, I would like to have Mr. John Singer present with me who is my accountant.

Mr. BARTON. Okay. John Singer, is he in the audience. Mr. Singer, if you'll come forward. If you'll all stand and raise your right hand, including Mr. Singer.

Do you swear that the testimony that each of you are about to give is the truth, the entire truth, and nothing but the truth, so help you God.

All do.

Okay. Be seated and then Mr. Singer, if you're needed, we'll just call you forward.

Mr. Coggins, your statement is in the record. We'll recognize you for 5 minutes.

TESTIMONY OF PAUL COGGINS, UNITED STATES ATTORNEY FOR THE NORTHERN DISTRICT OF TEXAS

Mr. COGGINS. Thank you. Is that—do I need to hold this to talk?

Mr. BARTON. Yeah, I think so, but it's working.

Mr. COGGINS. Thank you for your invitation to appear here. First I'd like to say, I am the U.S. Attorney for the Northern District of Texas. The Northern District of Texas encompasses a hundred counties in North Texas. It includes four of Texas' ten most populous cities and a hundred of Texas' hundred most beautiful counties.

On the health care fraud enforcement today, I'm going to be talking to you about civil enforcement and criminal enforcement. And I'd like to start out my by saying that recently Congress, the administration, made more resources available to the Department of Justice to fight health care fraud in the 1996 Act. That has made a big difference in our effectiveness in fighting this problem. And behind me in the audience is Pete Winn who worked predominantly in civil health care fraud enforcement. Pete was hired by our offices pursuant to funds made available in the 1996 Act.

Until recently, health care fraud was the most underinvestigated, underprosecuted area in white-collar fraud. The Department of Justice followed a two-pronged attack which includes not only enforcement but also pushing compliance programs to avoid the necessity of enforcement actions.

On the civil enforcement, our actions are generally brought under the False Claims Act. The False Claims Act only covers false claims that were done knowingly or with deliberate ignorance or reckless disregard of the falsity. And it is important to note that the False Claims Act covers far more than health care fraud, for example, it covers defense fraud as well. And in all cases whether—in all cases, the burden of proving the false claim was done knowingly or recklessly falls upon the government.

Under the False Claims Act one of the cases we're going to need to talk to you about today involves a recent settlement our office entered with Pro Med Pharmacies for approximately $1 million. Pro Med is headquartered in Amarillo, Texas. I'm glad that Mr. Donald Chrysler will be here to talk about that to you.

Pro Med was involved in paying kickbacks to durable medical equipment companies for patient referrals. Kickbacks have been a serious problem we have uncovered in our health care fraud investigations because they drive up the costs of goods and services and because they harm the individuals and companies that play by the rules. Our investigation determined that Pro Med did not begin the practice of paying kickbacks, but felt that it had to do that to compete with others who were doing so. The amount of the settlement reached with Pro Med represents roughly two times the kickback payments and the cost of the investigation. And one of the things that Mr. Chrysler and I are here to tell you is the absolute importance of having a level playing field in the health care fraud area.

Another important investigation our office worked on with a number of other offices involved National Medical Enterprises, that was a national investigation involving a chain of psychiatric hospitals in North Texas and elsewhere. The investigation uncovered kickbacks for patient referrals and a series of false claims.

We've had a number of convictions in this district of doctors and others in the health care area and sentences ranging everywhere from probation to 8½ years of prison. In addition, NME reached a settlement with the Department of Justice in the amount of approximately $370 billion and equally importantly entered into a corporate integrity plan which was one of the first of its kind.

One of the important points I'd like to make about the False Claims Act is that it does not cover, it does not extend to honest mistakes or even to negligence. And if a provider believes that it has been, it has made such an honest mistake or it has been negligent, it will have a chance to make that case before suit is filed. In my office, the United States Attorney's Office of the Northern District of Texas, we have an open door policy and in every one of these cases it benefits us to hear the other side before spending a lot of time and effort filing a lawsuit. But having said all that, our system presupposes that the provider will accept responsibility to ensure the accuracy of the bills being submitted.

A couple of representative criminal prosecutions we've had in the Northern District of Texas include one of a podiatrist, who basically misdescribed routine nail trimmings as nail avulsions and debridements in order to bring its coverage within Medicare. In addition, we've had a home health service which fabricated documents to the tune of about $500,000 which included ghost employees.

Fighting fraud in the Northern District of Texas has been a major priority since I became the United States Attorney in 1993. In 1994, we founded a regional health care fraud working group and one of the things we did was meet with private companies to determine the scope of the problem and the type of the problems we were having in the Northern District of Texas, we exchanged information. Because of the success of that working group, in 1995, we established a Metroplex Health Care Fraud Task Force which now has 18 agencies participating. We have approximately 90 ongoing health care fraud investigations in our office now.

We have two exploding areas that have already been touched upon, I've run out of time. I don't need to belabor the point, but obviously, they involve home health agencies and durable medical

equipment agencies. Health care investigations and prosecutions are time consuming, they are personnel intensive. The cost of the crimes include higher insurance premium and higher taxes. They, of course, divert their sources away from those most in need to those who are willing to break the rules.

We all have a stake in preventing health care fraud where we can, cracking down on health care fraud when necessary, and no one more so than the vast majority of honest doctors and honest providers out there who want to play by the rules. I welcome your continued interest in this problem and your help in our addressing it.

Mr. BARTON. Thank you, Mr. Coggins. Let's set the clock for 7 minutes. I think 5 is too little.

We're going to now hear from Mr. Richardson who is the Assistant Inspector General for Criminal Investigations. Now, Mr. Campbell, were you also here to testify or here to assist?

Mr. CAMPBELL. I'm here to assist.

Mr. BARTON. Your entire statement is in the record. We'll recognize you for 7 minutes.

TESTIMONY OF ROBERT E. RICHARDSON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS, OFFICE OF THE INSPECTOR GENERAL

Mr. RICHARDSON. Thank you very much. Good afternoon, Mr. Chairman, members of the committee. Mr. Campbell is a supervisor here in our Dallas office and his role, he—he selects which cases will be investigated by our office and has oversight of the actual investigations as the direct supervisor for the agents assigned to do the case work.

My responsibilities are in Washington. It is a pleasure to be here today and to have an opportunity to discuss Medicare fraud with you. It's clearly a problem. A little over 20 years ago the program expenditures were $22 billion a year. As the committee has already noted, our audit of the 1996 fiscal year indicates $23 billion in inappropriate payments. A figure now greater than the program of just two decades ago.

We do not know how much of that $23 billion is lost to fraud. We do know that there are some serious fraud issues and we've touched upon two of them already, home health and DME, and I would like to talk a little bit about both of those this afternoon. Albuterol Sulfate is a drug that is 68 percent of the—of the cost of all drugs that are administered through nebulizers. A piece of durable medical equipment that causes—changes the drug from a liquid into a vapor that can be inhaled. These drugs are priced in a way that allows for the pharmacy to pay a considerable kickback and a considerable incentive to a DME company for referrals and still make a tremendous profit on the drug.

In 1996, our Office of Evaluations and Inspections looked at nebulized drugs. They looked at this particular drug and what they found was in 55 percent of the retail pharmacies a Medicare beneficiary could buy the drug across the counter cheaper and at a lower price than Medicare reimbursed them. National chains, they looked at five large buying groups, all five of them had a price that was lower than Medicare. They looked at four mail order phar-

macies, all four had a price that was lower than Medicare. Clearly the problem is one of inappropriate incentives. Until the Health Care Financing Administration has the ability to set a price that gives no one an incentive to pay kickbacks, this will continue to be a problem.

Home health is the other issue we've touched upon here today. It is a growing area. The Administrator has noted that it is increasing at a rate greater than 25 percent per year. It is a problem area. Like DME, it is an area that has attracted entrepreneurs that are not people who have traditionally been in our health care systems. It is an area with inappropriate amount of control.

The OIG strongly supports bonds, surety bonds, for home health agencies. We strongly support applications that allow us to clearly identify with whom we're doing business and a process that determines whether or not a company is able to provide those services before we decide that we should be paying them to treat Medicare beneficiaries.

No matter what we do to correct abuses in the program, no matter what we do to take away incentives for people to steal from our programs, there will always be a need for strong law enforcement. Medicare is our largest expenditure, our largest single identifiable portion of our Federal budget, 13 percent. And with that much money, there will always be people who will target the system, because as Willie Sutton said, "Why do you rob banks? That's where the money is." There will always be a small number of people who will target the system because there are there is so much money.

So I would encourage you to continue to support as you have you have in the Health Insurance Supportability Accountability Act Legislation of 1996 and last years Balanced Budget Act and continue to support strong law enforcement efforts.

[The prepared statement of Robert E. Richardson follows:]

PREPARED STATEMENT OF ROBERT E. RICHARDSON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS, OFFICE OF INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon, Mr. Chairman and Members of the Committee. My name is Robert E. Richardson. I am the Assistant Inspector General for Criminal Investigations, Office of Inspector General, Washington, D.C. With me today is Martin A. Campbell, Assistant Regional Inspector General, Office of Inspector General, Dallas Texas Field Office. It is an honor to appear here today to discuss issues related to Medicare fraud and abuse. As you know, the Office of Inspector General's audit last year of the financial statements of the Health Care Financing Administration revealed Medicare losses of approximately $23 billion per year. While we do not know how much of that figure involves outright fraud, our investigative experiences here in the Dallas Field Office have disclosed substantial fraud and abuse issues. I will discuss two of those issues today. One issue involves the payments of incentives, a practice in the medical supply industry which inflates the cost of supplies and erodes confidence in the Medicare program. The other issue involves home health care fraud, an area where we have found a proliferation of entrepreneurs with little health care background. Both of these issues came to our attention during Operation Restore Trust, a two-year demonstration project focusing on home health fraud and abuse and fraudulent practices in the medical supply industry.

Illegal Kickbacks in the Medical Supply Industry

An Amarillo, Texas, a mail order pharmacy devised a scheme to pay illegal kickbacks to durable medical equipment (DME) companies for the referral of customers. The Medicare program provides reimbursement for certain pharmaceuticals administered through medical devices. One such drug, Albuterol Sulfate, prescribed for patients with certain lung disorders, is administered through an inhalation device called a nebulizer. The mail order pharmacy entered into agreements with DME

companies through which the DME companies were paid $30.00 per month for each patient referred for dispensing the Albuterol Sulfate. It is a violation of Federal law to pay incentives to induce referrals. The pharmacy recently entered into an agreement to pay the Federal Government $1,091,353 which includes twice the amount of the referral fees and the cost of the Office of Inspector General Audit which discovered the arrangement and the ensuing investigation. We are currently pursuing investigations involving other pharmacies and DME companies involved in similar activities.

Home Health Fraud

We are also investigating allegations involving numerous Texas home health agencies in connection with two areas of fraud and abuse, namely, false claims in cost reports and organized criminal activity having little to do with patient care.

Home health agencies are reimbursed by Medicare based on amounts claimed on annual cost reports. In one south Texas case, the owner of a home health agency has been charged under new criminal statutes created under the Health Insurance Portability and Accountability Act of 1996. These charges relate to the inclusion of over $1.2 million in expenses which were personal in nature and not related to the home health business or the care of Medicare patients.

A group of individuals in South Texas have opened over 60 home health agencies in the last two years. Investigations have revealed that these agencies have fraudulently billed Medicare for millions of dollars for care that was either never provided or was not necessary. The unnecessary services are bolstered by treatment plans signed by physicians who allegedly are paid illegal kickbacks. As individuals discover they are under investigation, they leave the country, taking the ill-gotten gains with them, and turn their businesses over to other members of their group. Most of the individuals involved in these investigations have little health care background or experience and some have criminal records. These investigations are continuing.

We are continuing to coordinate the efforts of our auditors, evaluators and investigators, with the assistance of the Health Care Financing Administration, to identify, investigate and seek prosecution of health care providers that defraud the Medicare program, its beneficiaries and the American public. I am prepared to answer any questions you may have at this time.

Mr. BARTON. Thank you. Mr. Campbell, you're here to just help answer questions?

Mr. CAMPBELL. Yes.

Mr. BARTON. Then we're going to go to Mr. Donald Chrysler, who is the Chief Executive Officer of Pro Med Pharmacy Company in Amarillo. And I understand that Mr. Baird, do you wish to introduce Mr. Chrysler or just help him answer questions?

Mr. BAIRD. I'll just help him answer questions.

Mr. BARTON. So Mr.Chrysler, we will recognize you for 7 minutes. Your entire written statement is in the record. And you are now at liberty.

TESTIMONY OF DONALD R. CHRYSLER, CHIEF EXECUTIVE OFFICER, PRO MED PHARMACIES, INC.

Mr. CHRYSLER. It's an honor for me to be asked to testify before the subcommittee today. I'd like to say that I've had the opportunity to work with Mr. Peter Winn, the Assistant U.S. Attorney here in Dallas, and I've been impressed with Mr. Winn's honesty and fairness.

I believe I have a unique perspective in testifying before the subcommittee. I'm the sole owner and Chief Executive Officer of Pro Med Pharmacies and National Home Health Care. Pro Med is based in Amarillo, Texas, and operates a full-line retail pharmacy and separate large mail-order pharmacy. Pro Med's mail-order operation specializes in dispensing respiratory medications to patients of all ages throughout the United States. Currently, Pro

Med's mail-order operations dispenses respiratory medications on a monthly basis to approximately 2,500 patients.

On the other hand, National Home Health Care is the largest full-line durable medical equipment company in the Texas Panhandle. National Home Health Care has offices in Amarillo, Texas; Hereford, Texas, and Clovis, New Mexico. National Home Health Care sells and rents soft goods, low tech medical equipment and high-tech medical equipment. The two companies combined employ approximately 110 employees and have a combined gross revenue of approximately $9 million per year.

Pro Med and National Home Health Care are classified as ancillary providers. I am defining an ancillary provider as a health care provider other than a hospital or physician. Increasingly, in our managed-care environment, health care is being provided by ancillary providers. As cost cutting becomes more prevalent, patient care is being removed from the hospital and physician setting and is being transferred to a home setting. This is where ancillary providers come in.

Home care is increasingly being provided by visiting nurses, DME suppliers, and pharmacies. In short, the importance of ancillary providers has grown. Payments by Medicare, Medicaid, and third party payers to ancillary providers has increased dramatically, and ancillary providers have become an important part of our Nations' health care system.

Most ancillary providers are honest, hardworking, and care very much for the patient. Unfortunately, as in any profession or industry, there is a small minority of ancillary providers that are not honest and do not have the patient's clinical needs at heart. This is where fraud and abuse comes in. Because billions of dollars are being spent every year for ancillary services, there is a motivation on the part of a small portion of ancillary providers to engage in fraudulent activities.

I see several fraud and abuse issues affecting pharmacies. The Federal Medicare anti-kickback statute, as well as a large number of comparable State statutes, provides that it is a crime for a provider to pay or offer to pay any type of remuneration directly or indirectly to a person or entity in exchange for a referral. This is broad language and even the most innocent of arrangements can at least technically be a violation of the Medicare anti-kickback statute and comparable State statutes.

Another issue facing pharmacies involves compounding. Generally speaking a pharmacy can compound a prescription only if it is not otherwise commercially available. As to whether a particular prescription is commercially available is sometimes ambiguous. If a pharmacy compounds prescriptions in accordance with the physicians' instructions, but if the Food and Drug Administration concludes that the same or similar product is otherwise commercially available, then the FDA might argue that the pharmacy's compounding is in violation of the Federal drug—or Food, Drug, and Cosmetic Act.

Particularly with mail order pharmacies, I'm aware of a problem wherein a pharmacy continues to ship their patient respiratory drugs that are simply not needed by the patient. It is important for the pharmacy to check with its patients on a monthly basis to

ascertain that the pharmacy is not oversupplying a patient with respiratory medication. By visiting with the patient on a monthly basis, the pharmacy can avoid this problem because it will be able to ask the patient whether he or she needs a complete shipment of respiratory medication for that particular month or whether the pharmacy should send a reduced amount or no shipment at all for that month.

As the owner of a DME company, I'm also generally aware of fraud and abuse practices in the DME industry. At times, a dishonest DME supplier will engage in what is known as "upcoding." For example, the DME supplier might sell to the patient and inexpensive, unsophisticated product. However, the DME supplier then turns around and bills the regional carrier for a much more expensive, sophisticated product. Other problems in the DME industry involves selling of products to patients that are simply not medically necessary or not even provided.

DME suppliers must not routinely waive copayments. Medicare policy requires that the DME supplier collect 20-percent of the allowable directly from the patient. By requiring the patient to pay a 20 percent copayment, this motivates the patient to obtain the item of medical equipment only if the patient feels that it is necessary.

Another fraud and abuse problem affecting the DME industry involves kickback arrangements. The life blood of the DME supplier involves referrals by referral sources such as physicians, hospital discharge planners, home health agencies, and nursing homes. If the DME company pays anything of value, directly or indirectly, to a referral source in exchange for referrals, then a violation of the Medicare anti-kickback statute and comparable State statutes occurs.

Pro Med is painfully aware of the fraud and abuse pitfalls that are out there. In the early 1990's, Pro Med entered into a nonfinancial arrangements with DME suppliers throughout the country, wherein the DME suppliers would refer their nebulizer customers to Pro Med, Pro Med would receive from the patients their Medicare assignment of benefits forms, Pro Med would dispense and mail prescriptions directly to the patients and Pro Med would then bill the regional carrier.

Mr. BARTON. Take your time. It's important that you get this on the record. So don't worry about the bell.

Mr. CHRYSLER. Pro Med has paid no money to the DME suppliers. This made the DME suppliers happy because they were able to offer to their patients a valuable service, delivery to the patients' homes their monthly respiratory medications. Unfortunately, as the market matured, a number of other pharmacies entered the fray.

To gain a competitive edge, Pro Med's competitors began offering compensation to the DME suppliers for services to be rendered by the DME suppliers to the pharmacies' patients. Pro Med refrained from competing in this fashion. Pro Med advised the DME suppliers, with whom Pro Med had worked over the years, that Pro Med felt uneasy about entering into these fee-for-service types of arrangements.

Unfortunately, Pro Med was the lone voice crying in the wilderness. Its DME suppliers questioned how Pro Med could be the only

pharmacy that was right while all other pharmacies were wrong. As a result, Pro Med lost the lion's share of its patient base and was faced with closing its doors. Pro Med was then forced to make a difficult decision. Should it continue to pay compensations to DME suppliers and probably close its doors, or should Pro Med compete with the other pharmacies by offering fee-for-service payments to DME suppliers? Pro Med chose the latter course of action. The upside is that Pro Med was able to stay in business and regain its market share. The downside is that Pro Med was investigated by the government.

Beginning in January 1997, the Office of Inspector General and the Department of Justice began conducting nationwide investigation of financial relationships between mail-order respiratory pharmacies and DME suppliers. In particular, the OIG and DOJ began examining the arrangement wherein the DME supplier would refer a nebulizer customer to a pharmacy for the customer's respiratory medication. And the pharmacy in turn, would contract with the DME supplier to pay the DME supplier to perform a designated list of services on behalf of the pharmacy for the customer.

Typically, as in Pro Med's case, the compensation to the DME supplier was one per patient, per-month basis. The OIG and DOJ has taken the position that such payments from the pharmacy to the DME supplier constitute illegal remuneration under the Medicare anti-kickback statute. The OIG and DOJ is investigating practically all of the pharmacies and DME suppliers throughout the country that engage in this type of relationship. In doing so the OIG and DOJ is demanding large civil monetary settlements from both the pharmacies and DME suppliers.

Pro Med is the first, and I believe the only, pharmacy to settle with the government. Pro Med and the government entered into a formal Settlement Agreement on September 30, 1997. In the Settlement Agreement, Pro Med denies the government's allegations that Pro Med's arrangements with DME suppliers violated the Medicare anti-kickback statute. Nevertheless, the government and Pro Med agreed to settle the government's claim against Pro Med. The Settlement Agreement provides Pro Med must pay the government $1,091,000 and will adopt and implement corporate compliance programs.

Obviously Pro Med is not happy about having to pay in excess of $1 million to the government. At the same time, Pro Med is grateful to the government and is grateful that the government has made its position known regarding the fee-for-service arrangements between pharmacies and DME suppliers. This makes the industry a level playing field, one in which Pro Med feels that it can complete successfully.

Permit me now to offer some constructive criticism to the government.

Mr. BARTON. We can't cut you off there, but do it quickly.

Mr. CHRYSLER. Normally, when the government perceives that a particular ancillary product or service is being overutilized, then the government overreacts and changes the eligibility criterion for the product. The result of which is—makes it very difficult if not impossible for a legitimate beneficiary to qualify for the product or service. Certainly, the government's action reduces utilization of

the product or service, but the government's action unfairly hurts honest ancillary providers and legitimate beneficiaries. When the government perceives that a product or service is being overutilized, then I would suggest that the government take a measured approach so that overutilization will end, but honest providers and legitimate beneficiaries will not be hurt.

Fraud and abuse statutes and regulations are vague. This vagueness allows a great deal of prosecutorial discretion. In a fraud and abuse investigation, the government wields tremendous power, that is, it certainly has a great advantage over the provider. Along with this power comes a great deal of responsibility. The government should continually make its views known to the industry concerning arrangements that might arguably be fraudulent or abusive. The government does not have a good track record in doing this in the past.

I could talk for hours or even days about issues affecting ancillary providers. However, I anticipate that you may have some questions to ask me and I know you're anxious to hear from the other members on the panel. I sincerely appreciate the interest you are showing fraud and abuse issues. As our elected officials become more conversant with how the health care system works, the incidences of fraudulent activities will decrease. Thank you.

[The prepared statement of Donald R. Chrysler, Jr. follows:]

PREPARED STATEMENT OF DONALD R. CHRYSLER, JR., CEO, PRO MED PHARMACIES, INC.

It is an honor for me to be asked to testify before the Subcommittee on Oversight and Investigations of the Committee on Commerce ("Subcommittee"). I have had the opportunity to work with Mr. Peter Winn, an Assistant United States Attorney out of the Dallas office, Mr. Winn works under Mr. Paul Coggins, the United States Attorney out of Dallas. I have been impressed with Mr. Winn's honesty and fairness.

I believe I have a unique perspective in testifying before the Subcommittee. I am the sole owner and Chief Executive Officer of Pro Med Pharmacies, Inc. ("Pro Med") and National Home Health Care, Inc. Pro Med is based in Amarillo, Texas; it owns and operates a full-line retail pharmacy and a separate, large mail-order pharmacy operation. Pro Med's mail-order operation specializes in dispensing respiratory medications to patients of all ages throughout the United States. Currently, Pro Med's mail-order operations dispenses respiratory medications, on a monthly basis, to approximately 2,500 patients.

On the other hand, National Home Health Care is the largest full-line durable medical equipment company in the Texas Panhandle. National Home Health Care has offices in Amarillo, Texas; Hereford, Texas; and Clovis, New Mexico. National Home Health Care sells and rents soft goods, low tech medical equipment and high tech medical equipment. The two companies, combined, employ approximately 110 employees and have a combined gross revenue of approximately $9 million per year.

As the owner of these two companies, I have a unique perspective on fraud and abuse issues affecting pharmacies and DME suppliers. I am aware of companies that strive to operate well within the established fraud and abuse guidelines; I am aware of companies that operate in the grey area; and I am aware of companies that are founded and operated on fraudulent principles.

Pro Med and National Home Health Care are classified as "ancillary providers." I am defining an ancillary provider as a health care provider *other than* a hospital or physician. Increasingly, in our managed care environment, health care is being provided by ancillary providers. As cost cutting becomes more prevalent, patient care is being removed from the hospital and physician setting and is being transferred to a home setting. This is where ancillary providers come in. Health care is increasingly being provided by visiting nurses, companies that provide enteral and parenteral feeding, home infusion companies, DME suppliers and pharmacies. In short, the importance of ancillary providers has grown. Payments by Medicare, Medicaid and third party payors to ancillary providers has increased dramatically, and ancillary providers have become an important part of our nation's health care sys-

tem. Most ancillary providers are honest, hard working and care very much for the patient, Unfortunately, as in any profession or industry, there is a small minority of ancillary providers that are not honest and do not have the patient's clinical needs at heart. This is where fraud and abuse comes in. Because billions of dollars are being spent every year for ancillary services, there is a motivation on the part of a small portion of ancillary providers to engage in fraudulent activities.

I see several fraud and abuse issues affecting pharmacies.

1. First, there are land mines that relate to pharmacies' marketing activities. The federal Medicare anti-kickback statute, as well as a large number of comparable state statutes, provide that it is a crime for a provider (such as a pharmacy) to pay, or offer to pay any type of remuneration, directly or indirectly, to a person or entity in exchange for a referral (or the arranging for a referral). This is broad language and even the most innocent of arrangements can at least technically be a violation of the Medicare anti-kickback statute and the comparable state statutes. For example, a pharmacy may wish to enter into an independent contract with a physician for the physician to serve as the medical director for the pharmacy. The physician might render very important clinical services for the pharmacy. However, the pharmacy must be extremely careful how it compensates the physician for his or her services lest the arrangement be perceived as a kickback arrangement (that is, pharmacy is paying compensation to the physician in the hope of receiving referrals from the physician). Another example might involve a pharmacy's desire to market its products and services to the general public. If the pharmacy enters into an independent contract with a marketing firm for the firm to promote the pharmacy's products and services to physicians, hospitals, nursing homes, etc. (the marketing firm would not be promoting the pharmacy's products and services directly to patients), then (depending on the compensation arrangement with the marketing firm) the arrangement might be looked upon as being a kickback arrangement in violation of the Medicare anti-kickback statute and comparable state statutes.
2. Another difficult issue facing pharmacies that bill government payors involves the collection and compilation of the required paperwork. For example, a mail-order respiratory pharmacy, before it can bill the regional carrier, must have on hand a properly completed prescription.
3. Another issue facing pharmacies involves compounding. Generally speaking, a pharmacy can compound a prescription only if it is not otherwise commercially available. As to whether a particular prescription is commercially available (and, thus, cannot be compounded) is sometimes ambiguous. If a pharmacy compounds prescriptions, in accordance with the physician's instructions, but if the Food and Drug Administration ("FDA") concludes that the same or similar product is otherwise commercially available, then the FDA might argue that the pharmacy's compounding is in violation of the Federal Food, Drug and Cosmetic Act.
4. Particularly with mail-order respiratory pharmacies, I am aware of a problem wherein a pharmacy continues to ship (or mail) to a patient respiratory drugs that are simply not needed by the patient. Respiratory drugs are normally taken by the patient in conjunction with a nebulizer. The patient pours the respiratory drug into the nebulizer, the nebulizer vaporizes the drug into a mist, and the patient breathes the mist through a small mask. Normally, a respiratory patient will take anywhere from two to four breathing treatments per day. It is important for the pharmacy to check with its patients on a monthly basis to ascertain that the pharmacy is not over supplying the patient with respiratory medication. If the patient is only taking two breathing treatments per day, but if the pharmacy ships drugs to the patient in an amount sufficient to provide four breathing treatments per day, then the pharmacy is delivering to the patient twice the amount of drugs that are necessary. By visiting with a patient on a monthly basis, a pharmacy can avoid this problem because it will be able to ask the patient whether he or she needs a complete shipment of respiratory medication for that particular month, or whether the pharmacy should mail a reduced amount of respiratory medications for that month, or if the pharmacy should simply skip a month.
5. Another problem in the mail-order pharmacy industry involves "upcoding." Here, the pharmacy might dispense a certain quantity of a drug (e.g., 120 unit doses of Albuterol.083) but then bill the regional carrier for a greater amount of another drug (e.g., 360 unit doses of Metaproterenol). This is intentional fraud, pure and simple.

As the owner of a DME company, I am also generally aware of fraud and abuse practices in the DME industry.

1. At times, a dishonest DME supplier will engage in its own version of "upcoding." For example, the DME supplier might sell to the patient an inexpensive, unsophisticated lymphodema pump. However, the DME supplier then turns around and bills the regional carrier for a much more expensive, sophisticated lymphodema pump. Another example might be that the DME supplier sells to a female patient a cheap adult diaper, but then bills the regional carrier for an expensive "adult female urinary collection device."
2. Another problem in the DME industry involves the selling of products to patients that are simply not medically necessary. A prime example of this involves the "seat lift fiasco" that occurred in the late 1980s. For whatever reason, a number of DME suppliers were able to convince physicians that it was medically necessary for them to prescribe expensive electronic luxury chairs for the physicians' arthritic patients. As a result, HCFA witnessed a dramatic increase in claims for reimbursement for seat lifts. Basically, this was a market created by DME suppliers and the physicians went along with it. Unfortunately, in most cases, the electronic seat lifts were not medically necessary for the patients.
3. Another problem in the DME industry involves billing for medical equipment that was not provided to the patient. For example, a DME supplier might have on hand copies of various physicians' signatures. The DME supplier is then able to prepare fake prescriptions and CMNs. The DME supplier bills the regional carrier for medical equipment or services that are not provided to the patient.
4. DME suppliers must not routinely waive co-payments. Medicare policy requires that the DME supplier collect 20% of the allowable directly from the patient. By requiring the patient to pay a 20% co-payment, this motivates the patient to obtain the item of medical equipment only if the patient feels that it is necessary (if the patient does not feel that the medical equipment is necessary, he or she usually does not want to pay the 20% co-payment). If a DME supplier routinely waives the 20% co-payment, then there is nothing stopping the patient from purchasing the medical equipment from the DME supplier, even if the medical equipment is not medically necessary. This is a waste to the Medicare program. It is critical that the DME supplier requires its patients to pay the 20% co-payment unless the patients can show a true lack of ability to pay the co-payment.
5. Another fraud and abuse problem affecting the DME industry involves kick-back arrangements. The life blood of a DME supplier involves referrals by referral sources such as physicians, hospital discharge planners, home health agencies and nursing homes. If the DME company pays anything of value, directly or indirectly, to a referral source in exchange for referrals, then a violation of the Medicare anti-kickback statute and comparable state statutes occurs. In the fraud and abuse arena, there is no such thing as a technical loop hole. The "smell test" is very much alive. If an arrangement smells funny, then it must be avoided. For example, if a physician is to serve as a medical director for a DME supplier, then the DME supplier needs to pay the physician a flat amount per month that cannot vary. Alternatively, the DME supplier can pay the physician an hourly amount. The flat amount per month or the hourly amount must be fair market value in relation to the services rendered. The payments from the DME supplier to the physician cannot be tied, directly or indirectly, into referrals from the physician to the DME supplier. Another arrangement involves a DME supplier approaching the hospital and suggesting to the hospital that the hospital refer all of its respiratory patients (that are being discharged) to the DME supplier. The DME supplier will "follow the patient home" and set the patient up on an oxygen concentrator and nebulizer. The DME supplier and the hospital then enter into a contract whereby the DME supplier pays the hospital a certain amount of money per patient per month for the hospital to "look after the DME company's patients" on a monthly basis. Again, these patients were referred to the DME supplier by the hospital in the first place. This type of arrangement is simply a subterfuge to allow the DME supplier to pay the hospital referral fees. Another example of a fraudulent arrangement involves a "sham joint-equity arrangement." Here, a DME supplier and a hospital might enter into a "50-50 joint venture." However, the DME supplier puts up all of the capitalization or allows the hospital to put up its share of the capitalization by deducting the hospital's capital requirements from its share of the profits. For a joint equity arrangement to pass the smell test, it must be based upon the same principles as a joint venture put together to capitalize a widget factory. That is, both sides must put up true risk capital and referrals from a referral source (such as a hospital) cannot be tracked.

Pro Med is painfully aware of the fraud and abuse pitfalls that are out there. In the early 1990s, Pro Med entered into non-financial arrangements with DME suppli-

ers throughout the country, wherein the DME suppliers would refer their nebulizer customers to Pro Med, Pro Med would receive from the patients their Medicare assignment of benefits forms, Pro Med would dispense and mail prescriptions directly to the patients, and Pro Med would then bill the regional carrier. Pro Med paid no money to the DME suppliers. This made the DME suppliers happy because they were able to offer to their patients a valuable service (delivery to the patients' homes of their monthly respiratory medications). Unfortunately, as the market matured, a number of other pharmacies entered the fray. To gain a competitive edge, Pro Med's competitors began offering compensation to DME suppliers for services to be rendered by the DME suppliers to the pharmacies' patients (that were referred to the pharmacies in the first place by the DME suppliers). Pro Med refrained from competing in this fashion. Pro Med advised the DME suppliers, with whom Pro Med had worked over the years, that Pro Med felt uneasy about entering into these "fee-for-service" types of arrangements. Unfortunately, Pro Med was the lone voice crying in the wilderness. Its DME suppliers questioned how Pro Med could be the only pharmacy that was "right" while all of the other pharmacies were "wrong." As a result, Pro Med lost the lion's share of its patient base and was faced with closing its doors. Pro Med was then forced to make a difficult decision. Should it continue to refuse to pay compensation to DME suppliers (the referral sources) and probably close its doors, or should Pro Med compete with the other pharmacies by offering fee-for-service payments to DME suppliers? Pro Med chose the latter course of action. The upside is that Pro Med was able to stay in business and regain its market share. The downside is that Pro Med was investigated by the government.

Beginning in January, 1997, the Office of Inspector General ("OIG") and the Department of Justice ("DOJ") began conducting a nation-wide investigation of financial relationships between mail-order respiratory pharmacies and DME suppliers. In particular, the OIG/DOJ began examining the arrangement wherein the DME supplier would refer a nebulizer customer to a pharmacy for the customer's respiratory medication, and the pharmacy, in turn, would contract with the DME supplier to pay the DME supplier to perform a designated list of services (on behalf of the pharmacy) for the customer. Typically, as in Pro Med's case, the compensation to the DME supplier was on a "per patient per month" basis. The OIG/DOJ has taken the position that such payments from the pharmacy to the DME supplier constitute illegal remuneration under the Medicare anti-kickback statute; that the pharmacy does not disclose these payments to Medicare, that the claims for reimbursement submitted by the pharmacy to Medicare do not reflect the pharmacy's payments to the DME supplier, and that, as a result, the pharmacy is submitting false claims to the Medicare program. The OIG/DOJ is investigating practical all of the pharmacies and DME suppliers throughout the country that engaged in this type of relationship. In doing so, the OIG/DOJ is demanding large civil monetary settlements from both the pharmacies and the DME suppliers.

Pro Med is the first (and I believe, only) pharmacy to settle with the government. Pro Med and the government entered into a formal Settlement Agreement on September 30, 1997. In the Settlement Agreement, Pro Med denies the government's allegations that Pro Med's arrangements with DME suppliers violated the Medicare anti-kickback statute; nevertheless, the government and Pro Med agreed to settle the government's claim against Pro Med. The Settlement Agreement provides that Pro Med must pay to the government $1,091,352.51 and will adopt and implement corporate compliance provisions In exchange for Pro Med's obligations under the Settlement Agreement, the government releases Pro Med from liability arising out of its prior fee-for-service arrangements with DME suppliers. The Pro Med Settlement Agreement will serve as a basic model for settlement agreements between the government and other pharmacies and DME suppliers.

Obviously, Pro Med is not happy about having to pay in excess of one million dollars to the government. At the same time, Pro Med is grateful that the government has made its position known regarding the fee-for-service arrangements between pharmacies and DME suppliers. This takes the industry back to the early 1990s where pharmacies paid no compensation for referrals. This make the industry a level playing field, one in which Pro Med feels that it can compete successfully.

Permit me now to offer some constructive criticism to the government.

1. Normally, when the government perceives that a particular ancillary product or service is being over utilized, then the government overreacts and changes the eligibility criterion; the result is that it is very difficult, if not impossible, for a legitimate beneficiary to qualify for the product or service. Certainly, the government's action reduces utilization of the product or service, but the government's action unfairly hurts honest ancillary providers and legitimate beneficiaries. When the government perceives that a product or service is being over utilized, then I would suggest that the government take a measured approach

so that over utilization will end but honest providers and legitimate beneficiaries will not be hurt.

2. Fraud and abuse statutes and regulations are vague. This vagueness allows a great deal of prosecutorial discretion. In a fraud and abuse investigation, the government wields tremendous power... it certainly has a great advantage over the provider. Along with this power comes a great deal of responsibility. The government should continually make its views known to the industry concerning arrangements that might arguably be fraudulent or abusive. The government does not have a good track record in doing this in the past.

I could talk for hours, even days, about fraud and abuse issues affecting ancillary providers, particularly DME suppliers and pharmacies. However, I anticipate that you may have some questions to ask me and I know you are anxious to hear from the other distinguished members on the panel. I sincerely appreciate the interest you are showing in fraud and abuse issues. As our elected officials become more conversant with how the health care system works, then the incidences of fraudulent activities will gradually decrease.

Thank you.

Mr. BARTON. Thank you. And we will have, I'm sure, several questions for you. Now, I'd like to turn to Dr. Bohn Allen, a past President of the Tarrant County Medical Association, practicing physician here in Tarrant County. I believe he's on the State Board of Texas Medical Association. He's here representing TMA. Your written statement is into the record in its entirety. We recognize you for 7 minutes, Doctor.

TESTIMONY OF BOHN D. ALLEN, TEXAS MEDICAL ASSOCIATION

Mr. ALLEN. Thank you, Mr. Chairman. On behalf of the 35,000 physicians and medical students of Texas, we want to welcome you to Texas and to address these issues. First, let me say that we as physicians are very concerned about waste, fraud, and abuse. Every dollar wasted or stolen from the Medicare or Medicaid program is one less precious health care dollar that can be directed to our patients. We appreciate your acknowledgment that the vast majority of physicians conduct their transactions with the Federal Government with the highest ethical and professional standards.

What are we doing as the TMA in regard to this problem? We have undertaken an aggressive educational approach to fraud and abuse for our members. We are working in close coordination with our State carrier to educate physicians with regard to Medicare requirements and the rules and regulations of HCFA. Physicians do want to do what is right.

In September 1997, the TMA provided each of its members with a copy of the documentation guidelines for the ENM codes which the carrier and HCFA would not provide. We felt that it was absolutely essential that the doctors know what the rules of the game were and what was expected of them.

We have formed a task force within the TMA to address this issue and educate our physicians with regard to issues of waste, fraud, and abuse. In April, all physicians of the TMA will receive a publication prepared by a panel of experts entitled: "Fraud and Abuse Prevention, What Every Physician Should Know." This will be closely followed up by a series of seminars entitled: "Straight Talk About Fraud and Abuse." We will encourage every physician and his staff to attend one of these seminars.

We want all physicians to understand the complex rules of dealing with the Federal Government and have them develop a compli-

ance program to ensure proper coding and filing of claims with HCFA. Our State Medicare carrier will participate in and support this series. While Texas physicians are entirely supportive of efforts to eliminate fraud and abuse in the Medicare and Medicaid system, we are also concerned that government initiatives in concert with the Inspector General and the FBI should not impose on all already overburdened clinicians bureaucratic requirements so excessive that they constitute a waste of limited patient-care resources.

In this respect the requirements for documentation of the new ENM guidelines will require a major overhaul before they can be implemented with any hope of cost effectiveness. We already have reports from physicians of examples of more time being required to document these guidelines than the time spent with the patient and this is of no little concern to us.

We applaud HCFA's decision to delay the implementation of the new guidelines until July 1, 1998, and we support AMA's call for further delay until January 1, 1999. The new standards are so complex, ambiguous, and time consuming, that physicians who are now trying to implement them into their practice are balking at seeing new Medicare beneficiaries. If it takes longer to document the service than to provide the services for discounted reimbursement and a threat of being charged with fraud and abuse, there is little incentive to participate in the program.

We urge HCFA to work with the AMA to pare down the requirements to essentials and produce a set of standards whose clarity and focus simplify rather than complicate the documentation process. Our patients need the doctor's expertise and experience in caring for their illnesses, not more paperwork. The focus of HCFA's concern should be on quality of care the beneficiaries receive and not the degree of documentation in the record. But we as physicians do realize and understand that adequate documentation must be necessary and must be present to afford reimbursement.

The whole process of filing claims, coding diagnoses and procedures, documenting services, and payment of claims has become so complicated and driven by the bureaucracy that not even HCFA, much less the physician understands it. For the sake of our elderly, we hope the Congress, HHS, HCFA, and carriers in concert with the Inspector General, the FBI, and State agencies will not take an overly aggressive approach to rooting out fraud and abuse, otherwise our Medicare beneficiaries may find that they have nowhere to go for health care.

We are already seeing physicians either dropping out of the Medicare program or severely limiting the number of Medicare patients they see. In the Metroplex, we're having a problem getting Medicare beneficiaries seen and a survey of our physicians reveals that the No. 1 concern is not the reduced reimbursement, but the fear of being charged with fraud and abuse and being fined, imprisoned, or eliminated from the system.

Physicians do want to take care of our own population, but if the process becomes so burdensome and onerous, they will be forced out of the system and everyone will lose. We appreciate your efforts and we applaud your efforts. None of us wants one single dollar

stolen from the system, because in this budget neutral system that we operate in, we're all robbed of resources to care for our patients.

To compliment one of the previous discussors, in this system, in this situation, the government has the ultimate power and authority over physicians, and it can destroy our system of care for the elderly. We want to work with you, the Congress, HHS, HCFA, to see that our Medicare patients receive all necessary and appropriate care. I know working together we can do this. We thank you and your committee.

Mr. BARTON. Next is Ms. Claudia Foster. She is the Administrator for Associated Home Health Care in Waxahachie, Texas. It's a home health care company that's family owned. Her husband, Don, either was here or is still here somewhere. Right there. So your entire statement is entered in the record. And we'd ask that you try to summarize it in 7 minutes.

TESTIMONY OF CLAUDIA FOSTER, ADMINISTRATOR, ASSOCIATED HOME HEALTH CARE

Ms. FOSTER. Thank you all very much. It is my pleasure, my privilege, and my honor to provide what I hope to be a real life testimony from a small town America.

I am a mother, a wife, a Republican baby boomer, and the owner of one of those deplorable home health care companies, you know, the ones stealing Medicare dollars. While I will not try to fool you into believing that I know everything about home health, I will tell you that I am an authority on the differences of what is morally and ethically wrong. I do not lie and I will not color my testimony today to try to make a name for myself. I could care less about anything except the elderly people that I represent, and my company allows me that privilege.

Now, let me warn you that the following testimony is intended for mature audiences, audiences with the guts enough to hear the cold hard facts. If any of you here today cannot face the truth head on, then I suppose you should ask me to excuse myself.

The reason I am here today is because of four words that crawl under my skin like a cancer; Medicare, waste, fraud, abuse. Relax, I'm not guilty as charged, and don't look to me for any true confessions. The only thing that you will be able to accuse me of is managing Medicare money with honesty and integrity. The only thing that I am guilty of though is putting up with far too many bureaucratic rule changes that are leaving vulnerable senior citizens right in the path of the storm.

Now, I realize that HCFA has a job to do and so do our intermediaries, but for God's sakes could they please come out from behind their desks for 1 day and walk with me in small town America?

Something that's not in my testimony that I need to put in here is that, in fact, on Friday of last week I had three visitors from HCFA and we spent a very delightful, eye-opening day.

Thank you Congressmen and Nancy for listening to those of us that walk the streets of small towns in our country. Could you please think about me before you put rulemaking in the hands of your entity whose life is not directly affected by a system or a bond that's going to make it impossible for me to survive.

Now, wait a minute. Don't even think that I am some air-headed female about to get give you some gut wrenching scenario of patient "X" who cannot get into the car to have their blood drawn at the lab. I agree with you that aide visits were venipuncture patients were in many, many cases out of hand. But did we have to throw the whole shooting match out of the window?

I'm not stupid enough to believe that fraud and abuse do not exist and nor do I believe that agencies are not overutilizing services. I'm telling you that fraud does exist and I'm saying that a long with you, I'm damn angry about it. It happens in Waxahachie, Texas. I see it alive and well and it's growing at alarming rates. But guess what else my eyes are telling me, that we have a system that was not set up to handle a problem of this magnitude and now I'm finding myself looking for somebody to take accountability for this cost reimbursement mess that I find myself in today. Once again, for the good old system, I am a scapegoat. Reputable home care agencies with a conscious are bearing the brunt of upset beneficiaries and I am terminating superior staff members because of crippling cost limits.

Would you like to know what you're going to be left to deal with when good little Claudia Foster shuts her door, you're going to have the other kind of agency that has chosen to ignore all of the information about the interim payment system, about surety bonds, and cost limits. This is the agency that is staying in business today by being around to admit patients that my rule abiding company discharges because they know longer qualify for care. And by the way, their claims continue to get paid. Why is this?

This agency would accuse me of patient abandonment and I in turn would say nothing because I have far too much class to stoop to arguing with anybody who doesn't know the difference between doing the right thing and cheating. So I ask you, has IPS handled any waste and abuse? I don't think so. And don't tell me that it hasn't had time to work. Crooks don't need time.

I would feel a whole better if somebody higher up would acknowledge that a mistake was made and that we must stop the madness before another senior citizen has to move into an institution. After all, the lives of our elderly are more important than my personally being able to survive what I will come to label as "The Home Care Crash of 1998." You see, I have nothing to lose here today. My company is near death and it will not take long for me to find an appropriate place for my talent. I have nothing to lose by telling the truth, no matter how much it hurts, or no matter how much it makes you angry.

Let me explain—can I keep going? Thank you.

Let me explain why we are in this mess today. A cost reimbursement system provides an open invitation for misuse and mismanagement, but you already know that. I need to take a deep breath for a moment and tell you as respectfully as I know how, that all of the measures currently being taken to rid us of system abuses are in and of themselves creating more chaos than any of us are equipped to deal with.

I go on record today as telling you there I will not sign any surety bond which holds me personally and financially accountable. The cost reimbursement system will not allow the establishment of

equity. So why do I want to place my life's earnings and my children's future at the hands of some bad mood wedge auditor that may decide to interpret something in my chart as fraudulent. It's not black and it's not white, it's all in the interpretation.

The dollar amount of the surety bond for my company is valued at $350,000. Since I have no equity, the insurance company will not write my bond. So in order to secure it, my husband and I must personally guarantee ten times the bond value in assets which calculates in at $3.5 million. Forget it. I won't do it. And better yet, why should I be made to post the bond when Medicare has nod no problem recouping my overpayments in the first place. On May 1, 1997, I received notice from my accountant, Mr. John Singer, that my cost report reflected a payable to Medicare of $95,817. On May 30, Medicare was issued a check in the full amount. Why was this? Because of sound business principles and a very conservative accountant. How about them apples? Surety bond you say? Don't go there with me.

If my visit numbers in Texas are so out of control, why do my claims get paid? If I am so abusive of the Medicare system, how do you explain that I have had zero deficiencies on my last three State surveys.

Mr. BARTON. Now, I'm not going to touch your apples, but you need to wrap it up in a minute or so.

Ms. FOSTER. You knew I was going to be long-winded.

Mr. BARTON. We've already given you about 10 minutes.

Ms. FOSTER. I'll wrap it up. The quick-fix approach of IPS has a strangle hold on my company and I will not be left to work under prospective pay. IPS is killing Associated and that is a tragedy for my community. Don't feel sorry for me, I'm a big girl. Feel sorry for the patients and the physicians that I can no longer serve.

In conclusion of my testimony today, I leave you with the following. When I despise things that are terrible and then stand my ground against them, I become brave.

To you my elected officials, and to you Nancy DeParle, I challenge you today to take over my company and my talent and use us as a model for making the necessary repairs to keep me and others like me working to make life better for those who paved the way for me today. Thank you.

[The prepared statement of Claudia L. Foster follows:]

PREPARED STATEMENT OF CLAUDIA L. FOSTER, ADMINISTRATOR, ASSOCIATED HOME HEALTH

My name is Claudia Foster. It is my pleasure, my privilege, and my honor to provide what I hope to be a "real life" testimony from small town America.

I am a mother, wife, republican babyboomer, and the owner of "one of those deplorable home health care companies"—you know, the ones that are stealing Medicare money! And yes, my credentials more than qualify me to be in this position. While I will not try to fool you into believing that I know everything about home health, I will tell you that I am an authority on the differences between what is morally and ethically right or wrong. I do not lie, nor will I color my testimony to try to make a name for myself. I could care less about anything except the elderly people that I represent, and my company that allows me this privilege. Just for your benefit, please note on my resume that I became a gerontologist long before it was fashionable to take care of senior citizens.

Now, let me warn you that the following testimony is intended for mature audiences—audiences with the guts enough to hear the cold hard facts. If any of you

present here today cannot face the truth head on, then I suppose you should ask me to excuse myself.

The reason that I am here today is because of 4 words that crawl under my skin like a cancer: Medicare Waste, Fraud, and Abuse

Relax I am not guilty as most home health agencies have been charged, and don't look to me for any "true confessions". The only thing that you will be able to accuse me of is managing Medicare dollars with honesty and integrity. The only thing that I am guilty of is putting up with far too many bureaucratic rule changes that leave vulnerable senior citizens right in the path of the storm. Now, I realize that HCFA has a job to do, and so do our intermediaries, but for God's sake, could they please come out from behind their desks for a moment and follow me into real America? In fact, I'd be happy if they could just agree on something as simple as whether or not a patient qualifies for home health. (refer to Feb. 10th Home Health Line, page 3 and 4)

Could you, our elected officials, and someone from HCFA please listen to those of us that walk the streets of real America? Could you please think about me before you put rule making in the hands of an entity whose life is not directly effected by a system or a bond that make it impossible for me to survive?

Now wait a moment! Don't even begin to think that I am some air-headed female about to give you another gut wrenching scenario of patient "x" who cannot get into a car to have blood drawn at the lab. I agree with you that aide visits for venipuncture patients were in some cases, out of hand. But did we need to throw the whole shooting match out of the window?

I am not stupid enough to believe that fraud and abuse do not exist nor do I believe that agencies are not overutilizing services. I am telling you that fraud does exist and I'm saying that along with you, I am damn angry about it. It happens in small town America—even in Waxahachie Texas. I see it alive and well and growing at alarming rates. But guess what else my eyes are telling me: I see a system that was not set up to handle a problem of this magnitude, and now I find myself looking for someone to take accountability for this cost-reimbursement mess that I find myself in today. I just can't get anyone to own up. Once again for my good old system, I, or shall I say we, have become scapegoats. Reputable home care agencies with a conscious are bearing the brunt of upset beneficiaries, and are terminating superior staff members because of crippling cost limits.

Would you like to know what you'll have left to deal with? What you will be faced with when good little Claudia Foster shuts her door, is the other kind of agency that has chosen to ignore all of the information about the Interim Payment System surety bond, or cost limits. This is the agency that stays in business by being around to admit patients that my rule abiding company discharges, because they no longer qualify for care. (By the way, their bills continue to get reimbursed. Why is this?) This agency would probably accuse me of patient abandonment, and I in turn would say nothing because I have far too much class to stoop to arguing with anyone who doesn't know the difference between doing the right thing, and cheating. So I ask you—has our "new system" handled any waste and abuse? I don't think so!!! Don't tell me that it hasn't had time to work. Crooks don't need time.

I would feel a whole lot better if someone higher up than myself would just acknowledge the fact that a mistake was made, and that something must be done to stop the madness, before another senior citizen has to move into an institution. After all, our nations elderly, are more important than my personally being able to survive what I will come to label as "The Home Care Crash of 1998". You see I have nothing to lose here today. My company is near death and it will not take long for me to find an appropriate place for my talents. I have nothing to lose by telling the truth, no matter how much it hurts, or no matter how angry it makes anyone.

Let me explain why we are in this mess today. A cost reimbursement system provides an open invitation for misuse and mismanagement. It is not necessary to work at being efficient—our costs are paid... period! The regulations presented in this cost reimbursement climate allow for various approaches of interpretation. At this point in time we have put an impossible task in the lap of the Health Care Financing Administration by asking them to give us a quick-fix payment approach, when in actuality, a problem lies with open-ended, unclear regulations, which ends up leaving interpretation in the eyes of the beholder. I challenge you to take a regulation, put it on the desk at HCFA, an intermediary, an agency, and a home-care nurse, and you will receive 4 different explanations. What ever happened to rules written in black or white, a given right or wrong, and a consequence for breaking them?

I need to take a deep breath for a moment and tell you as respectfully as I know how, that all of the measures currently being taken to rid us of system abuses are in and of themselves, creating more chaos that any of us are equipped to deal with.

I go on record today as telling you that I will not sign any surety bond, which holds me personally and financially accountable. The cost based reimbursement system governing my home health agency will not allow the establishment of any equity. Why do I want to place my life's earnings and my children's future at the hands of some bad mood wedge auditor that may decide to interpret something in my chart as fraudulent? Remember? No black, no white means an interpretation based the auditor that you happen to receive. The dollar amount of the surety bond for Associated Home Health is valued at $350,000. Since Associated is allowed no equity, the insurance company will not write the bond for my agency. In order to secure it, I must personally guarantee 10x the bond value in assets which calculates in at approximately $3.5 million dollars. Forget it. I won't do it. Better yet, why should I be made to post the surety bond when Medicare has had no problem recouping any overpayment from me in the first place? (see exhibit) On May 1, 1997, I received notice from my accountant that my cost report reflected a payable to Medicare of $95,817. On May 30, Medicare was issued a check in the full amount. How 'bout them apples? Surety bond you say? Don't even go there with me.

Now I ask you, if my visit numbers in Texas are so out of control, why do my claims get paid? If I am so abusive of the Medicare system, how do you explain that I have received zero deficiencies on my last three state surveys? I have only done what I was trained and allowed to do by my intermediary and HCFA.

These questions are leading me down the following path:

We have all become part of a mistake triangle: HCFA at one point, the intermediary at one point, and provider at one point. The blaming game will not solve anything. It is time to seek out another solution. I will offer today to volunteer my time and expertise to team with HCFA and my intermediary, and will offer any amount of hours needed to help get this system straightened out. The voices that need to be represented are the ones out in the field providing a life line of hope to ease the institutionalization fears of our elderly. Our nations elderly if given a choice, want to stay at home, yes, at home.

Congress, do not let HCFA continue to waste time on finishing and implementing IPS. We need them to spend this time revamping coverage guidelines and give us concrete rules in black and white, with definite, harsh consequences for deviation from them. The color gray will not cut it anymore. The quick-fix approach of IPS has a strangle hold on my company and hundreds of others as well. I will not be left to work under a Prospective Pay System. IPS has killed Associated, and that is a tragedy for my community. Don't feel sorry for me though—I am a big girl. Feel sorry for the patients and physicians that I can no longer serve. At this point, it is too late for HCFA to send me anymore threatening letters about how I explain Medicare payment reform. My patents have been well informed, and truthfully informed as the Medicare conditions of participation require. My patients know exactly where the ball began its bounce. There is no way that anyone will threaten me against telling the truth.

In conclusion of my testimony today, I leave you with the following:

When I despise things that are terrible, and then stand my ground against them, I become brave.

Now, to you my elected officials, and to you Nancy DeParle, I offer you the keys to Associated Home Health along with my resignation, in the hopes that you can figure out a better way to keep my home health agency alive. Good luck, and by the way, the Agency will no longer be able to afford your salary.

Mr. BARTON. Thank you. The chairman is going to recognize himself for 10 minutes and then we'll recognize Dr. Ganske and Dr. Coburn. Unfortunately, we're only going to have time for one round of questions because it's already 5:15, but there will be additional written questions that we will submit for the record.

The first question I have is to Mr. Richardson. I had a home health care provider come up to me at the break and accuse me of stacking the deck; which is hard to believe after Claudia Foster's testimony and Dr. Allen's testimony, but so be it. But one of the things I was asked was about this number that we had at our hearing about 2 or 3 months ago about 40 percent of waste, fraud, abuse, and home health care claims.

Do ou want to elaborate on that and on the study that came out last July based on records that were looked at from several years before that. Do you have any additional information you'd like to

enlighten us with about those studies or any studies that have been done subsequent to that?

Mr. RICHARDSON. I am familiar with the studies—the studies were limited to a group of States that had a disproportion—or that represented a disproportionate number of our Medicare beneficiaries. Operation Restore Trust looked at five States, those five States had 40 percent of the beneficiaries. The study that you're referring to was a selected sample. One can certainly argue that the sample might not be indicative of small town America. I would be the last person to be—to argue that it is. But in the home health agencies that we've reviewed, 40 percent of the payments were inappropriate.

Mr. BARTON. So that's a number as far as you know that the Inspector General at HHS have not backed away from.

Mr. RICHARDSON. That's correct. We have not backed away from that number.

Mr. BARTON. Mr. Chrysler, you've talked about a system in durable medical equipment and pharmacies where, I don't think you said this explicitly, but you basically feel like to stay in business you were forced to do something which the Justice Department is now signaling as illegal. That you fought against it, but in order to stay in business you decided to do what everybody else was doing.

How could we change the system so that the problem that existed with you would not be a problem any longer? That you wouldn't have to pay for referrals.

Mr. CHRYSLER. Well, what I feel like the problem was, was the ambiguity of the law. I think there's more than one legitimate interpretation of what the law says. And in the—with the lack of direction from—from the government to what their interpretation is going to be, the industry was left to interpret the law for themselves basically.

Mr. BARTON. But now do you feel that it should be legal to pay to get a referral and then basically charge the taxpayer for that?

Mr. CHRYSLER. No.

Mr. BARTON. No. So that's—now correct me, I'm not trying to put words in your mouth, but apparently that's what was happening. So I'll ask Mr. Coggins if he wants to comment on how to change the system. As the real world person I want to give you a chance.

Mr. CHRYSLER. Well, their safe harbors were written to help give guidance with respect to the Medicare anti-kickback statute. I don't think—I think the safe harbors need to go further in their explanation and—and——

Mr. BARTON. Let me just throw some possible solutions at you. What if we required transparency so that potential customers were available to anybody who wanted to look on a web site on the Internet or posted in the Federal Register so that, you know, the patient—the potential patient group was not a commodity—that only one company had access to, that would be one thing.

Another thing would be to go to some sort of a competitive bidding situation where you priced the market instead of priced according to some fee schedule that was based on a regional price survey. I mean, if those two things were in existence, I don't think your problem would have occurred.

Mr. CHRYSLER. That may have some possibilities.

Mr. BARTON. So that's something you'd be willing to look at.

Mr. CHRYSLER. Yes.

Mr. BARTON. Mr. Coggins, you're aware of this case. It's been settled, so, obviously, you can talk something about it. What would your proposed solutions be to this particular issue?

Mr. COGGINS. I think one of the things that did happen is that Congress created the opportunity for advisory opinions in certain areas. And that's an option that's open, I think. HHS can provide advisory opinions on what you can or can't do. I think the general principle is pretty clear. You can't pay a kickback, as you said, for a patient referral and then you have a question of what constitutes a kickback? Was it a kickback? Was it a disguised kickback?

One of the things I would like to address because Mr. Chrysler has been very forthright in dealing with our office, very forthright in coming here and talking this when he didn't have to do it. Is that we feel the key thing for most doctors and most providers, as I said, they want a level playing feel. They want to be given a chance to operate within the rules and make sure others are operating within the rules. And if that's going to happen, we're not going to be able to allow kickbacks to occur in this system, because the only thing a kickback system will do is raise the cost of goods and services for everybody. It's going to cost to taxpayers more money and the insurance companies more money in the long run.

Mr. BARTON. All right. Ms. Foster, you were fairly eloquent in your testimony about what you're not going to do, and I don't blame you, but you also admitted that there's a problem. Now, I think that it's appropriate that there be some financial accountability for health care providers.

Ms. FOSTER. I agree.

Mr. BARTON. And I think that it's appropriate to have some sort of surety bond. I'm with you on the issue of 10 times the personal liability. So give me a potential solution that we can work with HCFA and HHS. I mean, how do you get to where you want to be?

Ms. FOSTER. I'm not sure I have a solution for the whole big picture, but I do know that those of us that have done the right thing should be allowed some leniency.

Mr. BARTON. So one possible alternative is to look at your past record, if you have a record, and if it's a clean record, not have quite as high a bonding requirement; would that be a possible solution?

Ms. FOSTER. I'm not at all opposed to a bond. Personally, I would like to see a lot of agencies out of business because a lot of those agencies are thorns in my side.

Mr. BARTON. Now if—we've got a representative, not on the panel, but in the audience, from surety bond companies, and that representative has pointed out there have to be assets which can be pledged against the bond. If you're in a situation where by law you're not allowed to maintain equity in the business, how would you calculate the size of the bond or would you not even try to calculate it based on your business, simply calculated it based on your past practices of compliance? You understand the question?

Ms. FOSTER. I think so. I'm not certain and Mr. Singer can help me with this, when we do go to prospective pay, will we at that

point be allowed to have equity in our business? We will. So the problem really is between now and October 1, 1999.

Mr. BARTON. Now in terms of the interim system, the interim payment system, I've looked at it, I'm not in the home health care industry, obviously, but I've looked at it, and I think that it is an attempt to be fair in the transition to the full prospective payment system. Do you have things that you wish to put in writing on the record, maybe not today, but before we issue our final report about how you might want to fine tune this interim payment system? We have to have some way to get away from the open-ended system we have today.

Ms. FOSTER. So you're asking me for suggestions and possible solutions?

Mr. BARTON. Yes, ma'am. I'm allowed to do that as the chairman of the committee. I can ask for solutions.

Mr. GANSKE. It's just not done often.

Mr. BARTON. But you don't have to give them to me right now.

Ms. FOSTER. That's what I wanted to hear. If I don't have to come up with it today.

Mr. BARTON. That's the purpose of these hearings.

Ms. FOSTER. I'll come up with something I promise.

Mr. BARTON. You know we don't have a predetermined point of view. We actually, believe it or not, want to hear the truth and then try to make good policy based on what we think the truth will be.

Ms. FOSTER. I'll come up with something I promise. And all I'm concerned about is keeping the doors of my company opened and at the rate we're going it's looking bleak.

Mr. BARTON. I understand that. The chairman is going to recognize Mr. Ganske for 10 minutes.

Mr. GANSKE. Well, first of all, Mr. Chairman, I want to thank you for having this hearing. I've learned a lot and I think that everyone here has probably learned some very interesting things.

There's a pretty large home health care contingent in the audience, I can tell. So I want to share with you the inside skinny of what went on with the Balanced Budget Agreement because you may not hear this from your lobbyist in Washington, but this is what happened. When we were looking at home health care costs and trying to get a handle on this, there were basically two ways to develop changing policy.

One would be to set up a copayment for home health care. The proposal, in fact, I think Ms. Foster, you've told me personally that is something you would not be opposed to. And there are some in the home health care industry think that would be a good idea. But the home health care industry lobbyists put an absolute nix on that idea.

This was your representatives representing you in Washington saying, "No way, Jose," to that idea. So what was the alternative? The alternative was a prospective payment system similar to what the hospitals function under, guidelines as to related improvements. So that's what the agreement came to be.

The administrations—now listen carefully to this—the administration's interim system proposal that we've been talking about would have based the cap on 100 percent of an agencies' historical

cost updated for inflation. That's what the proposal was in the negotiations.

However, your representatives were concerned that that would reward the high cost providers and lock in the low cost providers. I'm sensitive to this problem. I understand why the health care industry decided not to go with a historical basis only for an interim prospective system. It's because—how many of you—how many of you are with the Visiting Nurse Association? Is there anyone here? There's a couple in the back.

Okay. Well, in Iowa, for instance, the VNA's have offered, I think, pretty efficient home health care at lower costs than some of the other agencies. They felt, and their voice was heard within the home health care industry, that if you use only a historical basis for the transition, that those agencies which have been cost efficient would be penalized. While those that have had higher costs would be benefited. This was the argument from the home health care industry lobbyists. We don't want a purely historical basis, so what came out of it?

A compromise was reached that blended the cap, 75 percent agency specific and 25 percent regional, to take into account differences from around the country. Within each region the blending will increase the cap for agencies that were below the regional average and it would decrease somewhat the cap for the agencies that were above the regional average. That was what your industry agreed to.

That's why the law is the way that it is. Because we recognized that if you're not going to go to a copayment system and you're going to go to a prospective payment system while you're developing the data, you've got to have an interim system. That's the facts. Now, there are some industry representatives who are proposing their own prospective payment system right now. They claim it's ready for immediate implementation, but we looked at that proposal. We did a detailed analysis of that proposal and there were some real problems.

The system is built around "bonus payments" to home health agencies. That system would reward agencies that avoid the sickest patients and skimp on the care that they provide to their patients. That's a real problem. So I think that it's useful for people who are involved in home health care to have an ongoing dialog with HCFA, but it's also very important for you to understand the background of where we're at at this particular moment in terms of this interim payment system.

Maybe this is something that the Medicare Commission will look at. I don't know, we will hold our first meeting this week. And I'm on it and so, I think it is an important thing. I've worked a lot with people who—personally with people who provide home health care and it's a necessary service that we want to do right.

Now, with that brief statement I just want to finish—I just have one question because Mr. Chairman, both Congressman Coburn and I have to catch airplanes pretty soon. But this isn't just for home health care, it's also for other providers.

I'd like Mr. Coggins to address the question about, you know, you're the U.S. Attorney. You're the guy that's going to have to interpret and look at this fraud and abuse problem. In the legislation

that Congress passed, there is a provision that calls for knowing and willful violation as a burden of proof on the government in terms of proving fraud and abuse.

I think it would be very important for the people in this audience to hear how you as the U.S. Attorney interpret those two words and if you could expand on that to inform me and to inform the members of the audience exactly how you're going to go about looking at these provisions. Because we've heard an awful lot of fear, I think, in this audience that, you know, somebody makes an honest mistake and they're going to have the force of government ramming them up against the wall. I wonder if you could address that.

Mr. COGGINS. I'd be happy to because knowingly and willfully are basically two words that are used in almost all provisions whether it's medical or other types of cases we do. It is an element of proof that we have to address and it's put in the statute to weed out two things; to weed out, as the Congressman mentioned, inadvertent billing errors, and everybody that's been in practice.

And I can promise you this, I wasn't a bureaucrat my whole life. I spent 10 years as a lawyer in private practice. And if you combed over every bill I sent over 10 years and I had to swear I never had an incorrect bill, no one could do that. We understand that. So it's to windle out inadvertent billing errors or even negligent billing errors. Because negligent billing errors are not the subject of either criminal or civil cases under the False Claims Act or other criminal statutes.

But it is important to know that in every case those words are a burden upon the government whether we're talking a civil case or a criminal case. And we have what I call an open-door policy in my office, which means that we try to give notice before we're going to take any kind of action to give our representative a chance to come in and say,"Hey, you got it wrong here. What you thought was a fraudulent scheme is not a fraudulent scheme. What you thought was disguised kickback was not a disguised kickback."

Having said that, most cases that we end up taking in our office are made not through an audit quite frankly, particularly the criminal cases, most are made by whistle blowers inside a corporation, inside a provider, who come to the government and say words to the effect that, "We have a service that was not covered by Medicare and we were instructed to change the code and file it some other way or we were told to bill for services we never rendered." Those are clear cases where you're talking about actual knowledge of a criminal act.

So, bottom-line, one of the reasons we formed our working group is to get feedback from industry representatives just as the Congressmen are here today. I try to make myself, I try to make Peter Winn of my office, available to industry groups that would like us to talk to them and we will make that standing offer to anybody here today, that if you get us a card and you want us to come out and visit with you and to understand and to walk into that small town with you and see what you're facing, we will be happy to do that and look forward to doing that. Because I recognize, as I said in my testimony, nobody has a bigger interest in cleaning up the system than people who are trying to operate honestly within that system. That's true whether you're talking about medical system,

whether you're talking about banking, or any other system. And that's what we're trying to do. Our resources are so limited in here we're going to have to go after the people who deserve to be put out of business and keep the people who are doing good jobs in business. Thank you.

Mr. BARTON. Dr. Ganske, did you want to have one final comment? For the final 10 minutes of questions, Congressman Coburn of Oklahoma.

Mr COBURN. I won't take 10 minutes. I want to get on my flight. Mr. Coggins, what you said about your office is great, but I want to tell you, not every U.S. Attorney has your attitude. And that's one of the things providers whether home health, or CME providers, they don't have that ability and I'm sorry Ms. DeParle left today, because one of the things she needs to hear is that you ought to have the ability in this country to be able to ask the government if what you're doing is right or wrong and them tell you rather than say, "We don't have to tell you. Try it and then we'll see."

We can change that. That's something that I'm sure most people would like to see changed. The reason it's not there is because what I said earlier about HCFA. It's an impossible set of tasks that we've asked them to do and so what we have to do is work toward it. I promised some home health people that I would ask this question. I want to ask this even though Ms. DeParle is gone. If you work for or are associated with a home health firm or are a lobby for that, would you please stand up.

Now, if your firm has a surety bond, stay standing. If you don't, sit down. Okay. So there are a significant number as Ms. DeParle said. Thank you.

Mr. BARTON. Ask if they all work for the same company.

Mr. COBURN. Do you all work for the same company? Yes.

Mr. BARTON. There are one or two women who weren't.

Mr COBURN. I want to say something to Ms. Foster. I listened with interest to your spunkiness. You reminded me of myself in Congress, which means you're going to get in trouble, but I tell you you're exactly the type that shouldn't quit. And if you say to HCFA, "No," then what happens is, is we're not going to change our government. It's only when you come to an interface with our government when you know it's wrong, you can't quit. That's when you dig in and try to change it harder.

And my comments to you are, is don't back down, don't change, stand there to toe to toe, and get it changed to where it's acceptable for the reputable firms.

Ms. FOSTER. Well, can you promise me that that could happen?

Mr. COBURN. No, I can't promise you anything. I'm a politician. Don't you know. All I can do is promise I'll be here for your delivery. Actually what you have to know is that, people like you quit, we lose. We all lose. The seniors lose. We lose as Members of Congress. Joe loses, HCFA loses. We have to fight.

The job that we all do every day is against the tendency for the government to take more of our freedom away. And when you express what you've expressed today, what you're saying is you're going to let them take more out of it. And what I want to leave you with is, you have an obligation to everybody else that's in-

volved in this health care to not quit, to change the system. I'm glad you're here and I want to encourage you to do that. And I'm on the way to catch my flight, Mr. Chairman, thank you.

Mr. BARTON. We're going to submit written questions for the record for this panel. I'm sorry we didn't have a second round, but we will have some written questions. I want to thank the city of Colleyville again for letting us use their facility as well as Dr. Coburn and Dr. Ganske for coming. Congressman Klink and some of the democrats couldn't come, but Congressman Klink had a death in the family.

We're going to do other hearings on this in Washington. We'll probably do other field hearings around the country. And as we've all tried to indicate, we're trying to find out what the issues are so that we can quickly move toward solutions. And especially those in the private sectors, your testimony is very, very helpful in that regard. This subcommittee is adjourned.

[Whereupon, at 5:47 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
May 12, 1998

The Honorable JOE BARTON
House of Representatives
Washington, D.C. 20515

DEAR CHAIRMAN BARTON: Thank you for holding the House Commerce Subcommittee on Oversight and Investigations March 2 field hearing on fraud, waste, and abuse. Fighting fraud, waste, and abuse is one of our highest priorities, and I greatly appreciate your interest and support in this effort. This letter includes the responses I promised for the record at the hearing, as well as responses to the letter you submitted from Representative James C. Greenwood with additional questions for the record.

Timetable for Centralized Claims Depository

You asked for a time frame of when we might have a centralized system that will allow us to make sure we are not receiving claims on the same patient from multiple parts of the country simultaneously. Medicare's existing Common Working File does have some capability to check for duplicate claims. The feature is used to check for duplication on every claim for durable medical equipment and on a sample of other types of claims. Improving the system is a high priority, but as you know, modernizing the Health Care Financing Administration's (HCFA's) computer systems has proved to be more challenging than we expected.

Our hopes for the Medicare Transaction System (MTS) were not realized, and we have learned the hard way that an incremental approach is best. Currently, our top priority is to ensure that all HCFA contractors and subcontractors have computer systems ready for the Year 2000. This is a daunting task, and until it is complete we cannot accurately gauge when we will be able to bring other necessary modernizations on line. HCFA is mandating that all contractors be in full compliance by December 1998, so we will have a full year to test the system to remove any remaining bugs.

At this point, a centralized claims depository will have to come after Year 2000 issues are completed.

Physician Accountability for Home Health

Representative Coburn asked about a provision of the law that holds physicians liable for the home health services they order. This provision, that was included in the Health Insurance Portability and Accountability Act of 1996, will allow the Department of Health and Human Services (DHHS) Office of the Inspector General to impose civil monetary penalties on physicians for improper certifications. I am happy to report that the Inspector General's office published a proposed regulation to implement this section of the law in the *Federal Register* on March 25. It is open for public comment until May 26.

Inherent Reasonableness:

The Balanced Budget Act of 1997 (BBA) made important changes in our ability to ensure that Medicare, and the taxpayers, are obtaining prices for goods and services that are competitive with what providers and suppliers charge other government agencies as well as the private sector in the market. The inherent reasonableness interim final regulation published on January 7 is an important tool to fight waste by helping us curb Medicare payments that are far higher than what other purchasers pay for the very same items.

1) Why did HCFA issue an interim final rule without opportunity for public comment?

We believe it is appropriate to publish the regulation as an interim final rule since it did not significantly change the existing methodology for application of the inherent reasonableness process that has been specified in regulations since 1986. We also believe that to delay implementation of these regulations by publishing a proposed rule would unnecessarily impede further savings to the Medicare trust funds and beneficiaries.

I want to emphasize that public comments are invited on interim final rules, and the comments we have received will be considered and discussed in the final rule.

2) The provision's legislative intent is to allow expedited payment reduction of no more than 15 percent. Yet HCFA states it will use this streamlined payment reduction authority to cut payment by more than 15 percent via cuts of up to 15 percent in each of several years... Please clarify.

The legislation states that the DHHS Secretary may reduce payments by no "more than 15 percent from such payment during the preceding year." Several studies show that Medicare often pays far more than 15 percent above what others pay for the very same goods and services. This is the case with home oxygen supplies and services, where estimates of overpayment range to 40 percent and higher. Inherent reasonableness reductions are limited to 15 percent per year so that the impact of reducing payments to appropriate levels would not be too great in any given year.

3) Providers maintain this rule includes no information on HCFA's methods to class payments as "inherently unreasonable" so that HCFA's data and calculations cannot be independently verified. Please clarify.

According to the statute, Medicare payments are inherently unreasonable when they are "grossly excessive or grossly deficient." The interim final rule which revises the current inherent reasonableness regulation retains many factors for determining whether payment amounts are grossly excessive or deficient and for setting realistic and equitable payment amounts. Criteria to be considered include: (1) whether payment amounts reflect changing technology, increased facility with that technology, or changes in acquisition, production, or supplier costs; (2) whether payment amounts are grossly higher or lower than payments for the same category of items or services by other purchasers in the same locality; (3) whether the marketplace is not competitive; (4) whether payment amounts in a particular locality grossly exceed amounts paid in other localities; (5) whether payment amounts grossly exceed acquisition or production costs; and (6) whether increases in payment amounts cannot be explained by inflation or technology.

4) Why does the rule provide only a 30-day notice prior to actual payment reductions?

The rule providing 30 days notice before the imposition of a special payment limit under this authority is not new. The 30-day time period is the same one used in the regulations on inherent reasonableness since 1986.

Competitive Bidding:

The competitive bidding demonstration required by the BBA allows us to test how to apply the market-based payment method to Medicare that most other payers, public and private, use to get good quality goods and services at fair prices.

Lessons learned from this demonstration will be highly valuable once we have legislative authority to use a common sense, market-based payment method that will allow us to use taxpayer's Medicare dollars more effectively.

1) What are the final criteria that will be used to determine successful bidders?

Suppliers will be asked to submit bids including prices for individual products and information on quality, experience, capacity, and geographic service area. These bids for individual products within each category will be aggregated into a single composite bid for the supplier by weighting the bids for individual products by the ratio of allowed charges for that item to the allowed charges of all items in the product

category during the most recent 12-month period. HCFA's contractor will then evaluate each supplier's composite price bid, but it is important to emphasize that we are not simply taking the lowest bidders. Suppliers also will be carefully evaluated for quality, capacity, and geographic service area. We will conduct on-site inspections of suppliers in the competitive range to verify their capacity and ability to meet quality standards.

2) What process will be used to ensure quality of care/service to beneficiaries in the demonstration sites?

Quality criteria, developed through consultation with a national technical expert panel, are being built into the bid specifications. Bidders will know in advance what quality standards they will have to meet, and will be expected to incorporate the costs of these standards in their bids. The bidders' past history of program compliance will also be part of the review. We will do a site survey of each supplier with a bid in the competitive range. We will have an ombudsman in place throughout the demonstration to investigate and resolve any complaints. Multiple violations of service criteria could lead to the suppliers' removal from the demonstration.

3) How will the financial impact of the project be evaluated/monitored?

For each demonstration site, we will select a nearby control site of about the same size, as well as compare usage and spending, before and after initiation of the competitive bidding project. We will measure the impact on suppliers by measuring changes in the volume and payments received by winning vs. non-winning bidders before and after initiation of the project.

Certificates of Medical Necessity:

Fraud, waste, and abuse have been particularly problematic with durable medical equipment, and that is why we insist the original copies of Certificates of Medical Necessity, bearing physicians' original signatures instead of faxed copies be maintained in the permanent file.

1) If a physician can fax a prescription for a narcotic, why doesn't HCFA accept a faxed true copy of a physician order for a wheelchair?

Unfortunately, the DHHS Inspector General, the General Accounting Office, and others agree that fraud, waste, and abuse is a major problem with durable medical equipment in Medicare, and one check against it is to make sure we are able to see the physician's original signature on Certificates of Medical Necessity. We accept faxed copies of these certificates to initiate delivery of equipment, but also require that suppliers follow up and obtain the original signed certificate for their files, because with faxed copies it is difficult to tell whether the signature is in fact valid. The DHHS Inspector General's office agrees with the need for this policy. A letter expressing the Inspector General's opinion is enclosed.

For narcotic drug prescriptions, there are several checks in place to ensure legitimacy, including strict rules and enforcement by the Drug Enforcement Administration.

2) In November 199 7, seven national health care provider associations formally petitioned HCFA to permit use of faxed Certificates of Medical Necessity. When will HCFA respond?

On March 16, we sent a letter to Irwin Cohen, an attorney who had inquired about HCFA's policy on behalf of several provider groups. The response explained the rationale and need for HCFA's policy to prevent fraud, waste, and abuse. It also explained that while HCFA has permitted suppliers to use a faxed Certificate of Medical Necessity to initiate delivery, the suppliers must still have the original signed Certificate of Medical Necessity on file. The Office of the Inspector General has stated that it has no objection to this requirement, providing that a time frame is established for when the supplier should have the original Certificate of Medical Necessity in its possession. A copy of our correspondence with Mr. Cohen is enclosed.

I am responding directly to Representative Greenwood with answers to his questions. In addition, on March 24, I sent a letter directly to Representative Coburn addressing his questions.

I appreciate your interest in these issues. I look forward to working with you as we continue our fight against fraud, waste, and abuse.

Sincerely,

NANCY-ANN MIN DEPARLE
Administrator

Enclosures

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November 20, 1997

BY FAX

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Room 3146
200 Independence Avenue, S.W.
Washington, DC 20201

Re: **Request for Issuance of a Policy on the Acceptance of Faxed Certificates of Medical Necessity and Physician Orders**

Dear Administrator DeParle:

I am writing on behalf of the organizations listed at the end of this letter to request that HCFA issue a policy regarding the acceptability of certificates of medical necessity ("CMNs") and/or physician orders that durable medical equipment ("DME") suppliers receive by fax from prescribing physicians. In this regard, all of the listed organizations have endorsed this letter in support of a policy that would allow for faxes of CMNs and physician orders to be used in lieu of original documents.

At present, there is no uniform policy regarding faxed CMNs that is accepted by all four of the regional DMERCs. The DMERCs for Regions B and D have developed written policies indicating that a physician may fax CMNs to the supplier so long as the supplier obtains hard copy originals of the CMN at some point and maintains those hard copies in its files. Region B officials have indicated, however, that faxed CMNs should only be sent by physicians in "urgent" situations (*i.e.* when it is necessary that a patient immediately receive an item). Region B Supplier Bulletin 96-05 (Dec. 1996). In addition, the Region B policy does not allow for uncompleted CMNs to be faxed to physicians for them to complete. Rather, a supplier must send an original double-sided CMN to the physician. Region B DMERC Suppliers Manual, Section XVIII. The Region D policy allows for faxes to be used under any circumstances, although they require that a hard copy must be eventually obtained. Region D DMERC Suppliers Manual, Section VII. The DMERCs for Regions A and C have no written policy regarding the acceptability of CMNs faxed to suppliers by physicians.

In addition, although all four regional DMERCs have a written policy indicating that a supplier must obtain and retain in its files the signed hard copy of a physician order, there is no written guidance regarding the use of faxes of physician orders. Region A DMERC Suppliers Manual § 12.4; Region B. DMERC Suppliers

Manual, Documentation; Region C DMERC Suppliers Manual § 4.4; Region D DMERC Suppliers Manual, Chapter VII.

In the context of modern business and government, faxes have become a generally accepted form of communication as well as an important tool for the conduct of business. Accepting faxes as an original would reduce the burden of creating additional paperwork. The amount of time that a DME supplier must spend to obtain a hard copy original of CMNs or orders signed by busy physicians can result in a significant business expense. As with all businesses, these increased expenses are eventually passed on to the public in the form of higher prices. Because reimbursement for DME is repeatedly being frozen or reduced while DME supplier costs are consistently increasing, suppliers must find ways to effectively reduce costs. Using faxes and not creating duplicative paperwork is a practical method for suppliers to use in reducing costs. In addition, there is a great deal of confusion on the part of DME suppliers regarding this issue because each of the regional DMERCs have a somewhat different policy and because two of the DMERCs have not yet reduced their policies to writing.

We, the organizations listed below, strongly believe that a fax is every bit as reliable as an original document and should uniformly be considered as an acceptable record. Faxes assure accuracy. A fax not only transmits an exact copy of the physician's signature but, a fax machine produces a byline that indicates the exact date and time that the fax was received as well as the phone number from which the fax was sent. This byline provides a method for suppliers and the government to assure that CMNs or physician orders were received timely and that they were actually sent by the signing physician. Thus, a fax may well provide some assurances of accuracy that even an original cannot. In addition we would recommend to all suppliers that the transmittals of all faxes include a reminder of the confidential nature of the materials being faxed.

Furthermore, the business value and convenience of using faxes is becoming increasingly accepted. In 1996, Federal Rule of Civil Procedure 5(e) was amended to increase the acceptance of faxes by federal courts. The advisory committee notes state that the "amended rule . . . makes clear the equality of filing by electronic means with written filings." Today, faxes are accepted by courts in a wide variety of contexts including: acceptance as valid contracts (see Schenk v. Red Sage, Inc., 1994 U.S. Dist. LEXIS 399 (S.D.N.Y. 1994) (court found a faxed document to constitute the final contract); Hofer v. Young, 45 Cal. Rptr. 2d 27, 30 (Cal. App. 1995) (finding contract where accepting party "communicated their acceptance by facsimile transmission within the requisite time period")); satisfaction of the statute of frauds (see WPP Group USA, Inc. v. The Interpublic Group of Companies, Inc., 644 N.Y.S.2d 205 (N.Y. App. Div. 1996) (The subscription requirement of the statute of frauds was met by an unsigned legend on a fax.)), acceptance as valid evidence (see People v. Guzman, 581 N.Y.S.2d 117 (N.Y. Crim. Ct. 1992) (faxed copy of supporting deposition sufficient to convert complaint into an information, provided certain safeguards ensure authenticity); People v. Flores, 526 N.Y.S.2d 125 (N.Y. App. Div. 1988), appeal denied 532 N.Y.S.2d

509 (facsimile of reproduced document admissible if original is in existence and available for production)); and use as an expert's affidavit.

Finally, HCFA, itself, accepts other than original documents in other circumstances. For instance, the Administration recognizes that Medicare enrollees often wish to keep the original itemized physician and supplier bills and thus, accepts photocopies of the itemized bills for Medicare deductible and payment purposes so long as there is no evidence of alteration. Medicare Part B Carriers Manual § 3003. For the reasons stated above, a fax is even more reliable than a photocopy.

We hope that you will take these requests under advisement and issue a policy regarding the acceptability of faxed CMNs and physician orders. We respectfully request that a meeting be arranged so that we could further discuss these issues with HCFA. On behalf of the organizations listed below, I thank you for your careful consideration of this important issue. Please call me if you have any questions.

Very truly yours,

Original signed by Irv Cohen

Irwin Cohen

On behalf of:

American Association for Respiratory Care
Mr. Sam P. Giordano
Executive Director
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Diabetic Product Suppliers Coalition
c/o Irwin Cohen, Esq.
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IC/SHL

cc: Frank E. Delillo, HCFA
Thomas Hoyer, HCFA

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Health Care Financing Administ

7500 SECURITY BOULEVA
BALTIMORE MD 21244-185

Refer to: FAN-0321

MAR 16 1998

- Call to Lew Morris
His opinion on

Irwin Cohen
Fulbright and Jaworski
L.L.P.
801 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2615

Dear Mr. Cohen:

In November 1997, you wrote to the Health Care Financing Administration (HCFA) requesting that we allow a faxed copy of a Certificare of Medical Necessity (CMN) to suffice as the original. In December 1997, we responded explaining that a supplier is responsible for and must have an original, hard copy, double-sided CMN on file for every beneficiary.

It has always been HCFA's position that the CMN is not an order but rather it is a record of the order and attests to the medical necessity of an item. The CMN is a payment safeguard tool used for items that are either highly abused or expensive. As a payment safeguard tool, we must require that the supplier maintain the original CMN on file.

HCFA, through the Durable Medical Equipment Regional Carriers, has issued bulletin notices telling suppliers that it is sufficient to use a faxed CMN to initiate a delivery so long as the supplier obtains an original double-sided copy of the CMN, signed by the physician within a few days. As stated, the supplier is responsible for keeping the original CMN on file and a faxed copy of the CMN is not considered an original. In response to this issue, the General Counsel for the Office of Inspector General has issued an opinion on this matter, stating that only a CMN which contains an original signature is considered the original CMN.

We hope that this addresses your concerns.

Sincerely,

William Gould
Director
Division of Program Integrity Operations

February 23, 1998

Note to Laurie Ballantine

You have asked whether the Office of Inspector General would object to the Health care Financing Administrations' contractors allowing durable medical equipment (DME) suppliers to rely on faxed certificates of medical necessity (CMN) pending the receipt of the original CMN from the ordering physician. Apparently DME suppliers are experiencing difficulties in getting the original CMN from the physician's office and would like to rely on the faxed CMN for billing Medicare. Under the current program policies, the supplier must have the original CMN on file prior to billing the program. Under the modified procedure, DME suppliers would be permitted to submit claims for services pending receipt and retention of the original CMN.

I have discussed your question with the Office of Investigations and can report that the OIG does not have an objection to this proposal. Provided that the DME supplier eventually has the original CMN in its files, we believe that is sufficient to permit an investigation into the authenticity of the CMN. At the same time, we would strongly suggest that the new guidance establish a time frame by which the supplier must have the original CMN in its possession.

If the contractors are sending out clarification on this issue, we would suggest that it would also be helpful to remind suppliers that they should have the beneficiary's signature on the claim form, or if appropriate, on file. We believe that an informed beneficiary is a key safeguard against the fraudulent submission of claims and that contractors should reinforce the beneficiary's role in verifying the claim.

Thank you for giving the OIG the opportunity to comment on this proposal. Please let me know if we can be of any additional assistance.

Lewis Morris
Assistant Inspector General for
Legal Affairs

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